**Patient Medical Summary**

Please answer the following questions related to your medical history.

Do you have an Advance Directive?

|  |  |
| --- | --- |
|  | No |
|  | Yes |
|  | Declined to respond |

If so, what type of Advance Directive do you have?

|  |  |
| --- | --- |
|  | Living will |
|  | Medical durable power of attorney |
|  | Other |

Please list any *new* medical procedures:

Do you smoke?

|  |  |
| --- | --- |
|  | Never (less than 100 times in lifetime) |
|  | 4 or less cigarettes (less than 1/4 pack) |
|  | 5-9 cigarettes (between 1/4 to 1/2 pack) |
|  | 10 or more cigarettes (1/2 pack or more) |
|  | Decline tobacco questionnaire |
|  | Other: |

Please include a current medication and allergy list when returning your paperwork to the receptionist. If you do not have one, please let the receptionist know. Thank you!

**Patient Health Questionnaire**

How often have you experienced one of the following symptoms over the past two weeks? Please check the option that best describes you.

Little interest or pleasure in daily activities within the last 2 weeks?

|  |  |
| --- | --- |
|  | No - Not at all |
|  | Yes - More than half the day(s) |
|  | Yes - Several days |
|  | Yes - Nearly every day |

Feeling down, depressed, or hopeless in the last 2 weeks?

|  |  |
| --- | --- |
|  | No - Not at all |
|  | Yes - More than half the day(s) |
|  | Yes - Several days |
|  | Yes - Nearly every day |

If you have answered “Yes” to either of the above questions, please answer the following questions:

Difficulty falling or staying asleep:

|  |  |
| --- | --- |
|  | Not at all |
|  | More than half the day(s) |
|  | Several days |
|  | Nearly every day |

Feeling tired or little to no energy:

|  |  |
| --- | --- |
|  | Not at all |
|  | More than half the day(s) |
|  | Several days |
|  | Nearly every day |

Poor appetite or overeating:

|  |  |
| --- | --- |
|  | Not at all |
|  | More than half the day(s) |
|  | Several days |
|  | Nearly every day |

Feeling bad or down about yourself:

|  |  |
| --- | --- |
|  | Not at all |
|  | More than half the day(s) |
|  | Several days |
|  | Nearly every day |

Trouble concentrating:

|  |  |
| --- | --- |
|  | Not at all |
|  | More than half the day(s) |
|  | Several days |
|  | Nearly every day |

Moving or speaking slowly:

|  |  |
| --- | --- |
|  | Not at all |
|  | More than half the day(s) |
|  | Several days |
|  | Nearly every day |

**Functional Assessment**

Please answer the following questions concerning mobility and function.

When you wake up in the morning do you feel stiff and/or sore?

|  |  |
| --- | --- |
|  | No |
|  | Yes |
|  | Most of the time |
|  | Some of the time |

Stiff Sore Both

If yes, about how long does it take until you start feeling better?

|  |  |
| --- | --- |
|  | 10-15 Minutes |
|  | 30 Minutes |
|  | 45 Minutes |
|  | 60 Minutes |
|  | 1-2 Hours |
|  | Longer than 2 Hours |

Please select the general locations you experience the majority of your pain:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Head (Headaches/Migraines) |  | Wrist(s) |  | Hip(s)/Pelvic Region |
|  | Neck |  | Hand(s) |  | Upper Leg(s) |
|  | Shoulder(s) |  | Chest |  | Lower Leg(s) |
|  | Upper Arm(s) |  | Torso |  | Knee(s) |
|  | Lower Arm(s) |  | Upper Back |  | Ankle(s) |
|  | Elbow(s) |  | Lower Back |  | Feet |

On a scale of 0-10 with ten being unbearable pain, what is the average of your pain in the past 24-48 hours? Please circle the best choice that describes your pain.

**0-No Pain 1 2 3 4 5 6 7 8 9 10-Worst**

Have you had any bad reactions to any of your current medications since your last visit?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

Have you had any rashes or mouth sores in the last 30 days?

|  |  |
| --- | --- |
|  | Yes |
|  | No |
|  | Mouth sores |
|  | Rash |

Do you feel rested in the morning?

|  |  |
| --- | --- |
|  | Yes |
|  | No |

If no, how many times do you wake from your sleep due to pain?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 1 |  | 2 times |  | More than 3 times |
|  | 1-2 times |  | 2-3 times |  |  |

|  |  |  |
| --- | --- | --- |
| **When was your last eye exam?** | Month: | Year: |

**For Patients over 65, please answer the following questions**

Please selected the option that best describes you.

If any, how many falls have you experienced within the last year?

|  |  |
| --- | --- |
|  | None |
|  | One **without** injury |
|  | One **with** injury |
|  | Two or more falls **without** injury |
|  | Two or more falls **with** injury |

Do you feel unsteady when standing or walking?

|  |  |
| --- | --- |
|  | No |
|  | Yes |

Do you have a fear of falling?

|  |  |
| --- | --- |
|  | No |
|  | Yes |

**Immunization History**

COVID 19 Vaccine Status: Number of COVID Vaccine Doses:

|  |  |
| --- | --- |
|  | Not Received |
|  | Pfizer Vaccine |
|  | Moderna Vaccine |
|  | Johnson & Johnson Vaccine |
|  | Other |

|  |  |
| --- | --- |
|  | 1 Dose |
|  | 2 Doses |
|  | 3 Doses |
|  | Greater Than 3 Doses |

Have you received an influenza If you do not plan to get a flu shot, why not?

vaccine this flu season?

|  |  |
| --- | --- |
|  | Yes |
|  | No, but plan to get one |
|  | No, do not plan to get one |
|  | Unknown |

|  |  |
| --- | --- |
|  | Allergy/Sensitivity to Flu Shot |
|  | Allergy to Egg |
|  | Allergy to Latex |
|  | Bone Marrow Transplant in last 6 months |
|  | Guillan-Barre Syndrome in the last 6 months |
|  | Patient/Family Refusal, Personal Preference |
|  | Vaccine Not Available |
|  | Physician Recommendation |

If you are OVER THE AGE OF 65 OR If OVER THE AGE OF 65 OR UNDER THE AGE OF 18

UNDER THE AGE OF 18, have you and have never received Pneumonia Vaccine,

received a Pneumonia Vaccine? why not?

|  |  |
| --- | --- |
|  | Yes, within the past 5 years |
|  | Yes, more than 5 years ago |
|  | Never Received |
|  | Unknown |

|  |  |
| --- | --- |
|  | Bone marrow transplant within the last 12 months |
|  | Chemotherapy within the past 2 weeks |
|  | Currently on scheduled course of chemotherapy |
|  | Currently on scheduled course of radiation |
|  | Radiation within the past 2 weeks |
|  | Other vaccine received in the last 8 weeks |
|  | Shingles vaccine in the past 4 weeks |
|  | Patient/Family Refusal, Personal Preference |
|  | Vaccine Not Available |
|  | Physician Recommendation |