

DEMOGRAPHICS

NAME: _____

Date of Birth: _____ Age: _____ Gender: _____

Date of Last Wellness Visit: _____ Location / Provider Name: _____

INFECTIOUS DISEASE RISK SCREEN

Recent travel history within the last 2 months.

Recent Travel History	None	Yes	
		Date	Location
Self	<input type="radio"/>		
Family Member / Household / Contact Travel History	<input type="radio"/>		

COVID-19 Screening – select one of the following.

<input type="radio"/> None	<input type="radio"/> Community exposure to COVID-19 within the last 14 days	<input type="radio"/> COVID-19 Symptoms Present	<input type="radio"/> Exposure to respiratory illness of unknown etiology	<input type="radio"/> Healthcare exposure to COVID-19 within the last 14 days
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HEALTH STATUS (CARE PROVIDERS)

Other Doctors

Other than your Primary Care Provider, what other doctors provide care for you? Please list below.

PROVIDER NAME, SPECIALTY, AND REASON



Other Medical Services (Ancillary Services)

What other medical services do you use? Please list below.

NAME, SERVICE, CONTACT INFORMATION, LOCATION, COMMENTS.

SERVICE EXAMPLES: Audiologist, Bath Aid, Dietetics, Home Health, Meals on Wheels, Pharmacy, Therapy: (Physical, Occupational, Respiratory, Speech), Social Services.

Medical Devices

Do you have any of the medical devices listed below?

- None
- Implantable cardioverter-defibrillator
- Insulin Pump
- Medication Pump
- Pacemaker
- Other: _____

Medical Equipment

Do you have any of the following medical equipment?

- None
- Oxygen therapy
- Walker
- Wheelchair
- Bed
- Commode
- CPAP
- Spirometry
- Splint
- Immobilizer
- Other: _____

Have you been hospitalized since your last visit (circle one)? **YES** or **NO**. *If yes, continue.*

	Were you in the Hospital?		Were you in the ER?	
	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
Date of Discharge				
Date of Follow-up Visit				
Was a Discharge Plan Provided?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No
Were your hospital medications reconciled with your current meds?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Yes	<input type="radio"/> No



CHRONIC PROBLEMS & ILLNESSES

List any ongoing or chronic medical problems or illnesses:

PROCEDURE HISTORY

List history of surgeries and hospitalizations with approximate date:

ALLERGIES AND MEDICATIONS

ALLERGIES

List any medication allergies and the reaction that you have to that medication:



SOCIAL HISTORY

Do you smoke tobacco (circle one)? YES or NO

If yes, about how many/day? _____

Do you feel you need to change this habit? YES or NO

Any concerns about tobacco use in your household? YES or NO

Have you ever used electronic cigarettes/vaping? (circle one)? YES or NO

If yes, current status? _____

Do you feel you need to change this habit? YES or NO

Passive exposure? YES or NO

Do you drink alcohol (circle one)? YES or NO

If yes, about how many drinks per week? 0-3 3 or more

If 3 or more drinks per week, how many per day? 0-2 2-5 5 or more

What is your favored drink type? Beer Wine Liquor Other: _____

Do you feel you need to change this habit (circle one)? YES or NO

Do you use other substances such as marijuana or other drugs (circle one)? YES or NO

If yes, about how many times? Per week _____ Per day _____

Nutritional History

What type of diet do you adhere to?

- Unrestricted/normal
- Calorie restricted
- Vegetarian
- Kosher
- Diabetic
- Renal
- Other(such as sodium restricted): _____

Exercise History

How many days do you exercise each week? 0-2 2-4 4-6 6+

Circle the average number of minutes you exercise in a day: 0-15 15-30 30-45 45-60 60+

What types of exercise do you prefer?



- Aerobics Bicycling Organized team sports Running Swimming
- Walking Weight lifting Yoga Other: _____

From your point of view what condition are you in?

- Poor Fair Good Excellent

DEPRESSION SCREENING

How many days in the last two weeks have you been bothered by the below symptoms?

- Little Interest, Pleasure in Activities Not at all Several Half or More Nearly All
- Feeling Down, Depressed, Hopeless Not at all Several Half or More Nearly All

Please continue on to the following questions, if you chose an option other than "not at all" from the questions above. If you have chosen "not at all" to both questions, you may skip to the next section.

How many days in the last two weeks have you been bothered by the below symptoms?

- Trouble Falling or Staying Asleep Not at all Several Half or More Nearly All
- Feeling Tired or Little Energy Not at all Several Half or More Nearly All
- Poor Appetite or Overeating Not at all Several Half or More Nearly All
- Feeling Bad about Yourself Not at all Several Half or More Nearly All
- Trouble Concentrating Not at all Several Half or More Nearly All
- Moving or Speaking Slowly Not at all Several Half or More Nearly All
- Thoughts about Hurting Yourself **** Not at all Several Half or More Nearly All

****IMPORTANT:** If you responded Several, Half or More, or Nearly All to this question complete the section titled SUICIDE RISK SCREEN.

- Difficulty at Work, Home, or Getting Along with Others Not at all Several Half or More Nearly All



Not a part of medical record

Patient Initials _____

SUICIDE RISK SCREEN

Please answer these questions if you responded Several, Half or more, or Nearly all to *the Thoughts about Hurting Self* question within the Depression Screening.

- 1) In past month, have you wished you were dead or wished you could go to sleep and not wake up? Past month, yes Past month, no
- 2) In the past month, have you actually had thoughts about killing yourself? Yes No

If you answered yes to question 2, please complete questions 3-5. If you answered no to question 2, please skip to question 6.

- 3) In the past month, have you been thinking about how you might kill yourself? Yes No
- 4) In the past month, have you had these thoughts and had some intention of acting on them? Yes No
- 5) In the past month, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? Yes No
- 6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? Yes No

If you answered yes to question 6, please answer question 7.

- 7) In the past 3 months, have you done anything, started to do anything, or prepared to do anything to end your life? Yes No

HEARING AND VISION

- 1) Do you wear corrective lenses? (Glasses or contacts)? YES or NO
- 2) Do you have difficulty with your hearing? YES or NO

HOME SAFETY

- 1) Are emergency numbers kept by the phone and regularly updated? YES or NO
- 2) Are all household members aware of the dangers of smoking, especially in bed? YES or NO
- 3) Are working smoke alarms and fire extinguishers available for use? YES or NO
- 4) Do all household members know how to use them? YES or NO
- 5) Are all firearms stored unloaded and securely locked? YES or NO
- 6) Have rugs been removed or fastened down? YES or NO



- 7) Are non-slip mats in all bathtubs and showers? YES or NO
- 8) Do all stairways have a railing or banister? YES or NO
- 9) Are sidewalks and all other steps clear of tools, toys, and other articles? YES or NO
- 10) Are doorways, halls, and stairs free of clutter? YES or NO
- 11) Are all electrical cords in working order, easily seen, and not run under rugs/carpets or wrapped around nails? YES or NO

FUNCTIONAL ASSESSMENT

Check the box which indicates who completes these tasks for you.

- Bathing or Showering Self Some help from others Others
- Dressing Self Some help from others Others
- Transferring to bed or chair Self Some help from others Others
- Using the Restroom Self Some help from others Others
- Eating Meals Self Some help from others Others

FUTURE PLANNING

- Do you have an advance directive? YES or NO
- If yes, does PSMC have a copy of it? YES or NO
- If no, please provide a copy to PSMC for our records.*
- If you do not have an advance directive, do you wish to receive further information? YES or NO

IMMUNIZATIONS

- Have you received a Covid-19 vaccination?
- Yes, series started
 - Yes, series completed
 - No
 - Declined



STABILITY SCREEN

Have you fallen in the past year?	YES	or	NO
How many times?	0	1	2+
Were you injured?	YES	or	NO
Do you feel unsteady standing or walking?	YES	or	NO
Do you worry about falling?	YES	or	NO

OPIOID RISK

Respond to these questions based on **family** history.

1) Do you have a family member with a history of substance abuse? *Select male and/or female as appropriate for each item.*

	Was the family member female?	Was the family member male?
Alcohol	<input type="radio"/>	<input type="radio"/>
Illegal Drugs	<input type="radio"/>	<input type="radio"/>
Prescription	<input type="radio"/>	<input type="radio"/>

Respond to these questions based on your **personal** history.

2) Do you have a history of substance abuse? *If yes, mark under the column for your gender.*

	Are you a female?	Are you a male?
Alcohol	<input type="radio"/>	<input type="radio"/>
Illegal Drugs	<input type="radio"/>	<input type="radio"/>
Prescription	<input type="radio"/>	<input type="radio"/>

- | | |
|---|-----------|
| 3) Are you between 16 – 45 years of age? | YES or NO |
| 4) Do you have a history of Preadolescent Sexual Abuse? | YES or NO |
| 5) Psychological Disease? | YES or NO |
| Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia | |
| 6) Depression? | YES or NO |



THE CARE YOU DESERVE, IN THE MOUNTAINS YOU LOVE

Not a part of medical record

Patient Initials _____

Reviewed / Revised 2/28/2018, 11/19/2020, 9/22/2021

PAIN ASSESSMENT

If you have pain, please complete the following:

Pain location: _____

Is the pain?	What is the quality of the pain?		Time pattern:	What is your pain score?
<input type="radio"/> Bilateral <input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Midline	<input type="radio"/> Aching <input type="radio"/> Burning <input type="radio"/> Cramping <input type="radio"/> Discomfort	<input type="radio"/> Sharp <input type="radio"/> Stabbing <input type="radio"/> Tender <input type="radio"/> Other <hr/>	<input type="radio"/> Acute <input type="radio"/> Chronic <input type="radio"/> Constant <input type="radio"/> Intermittent	<p><u>Scale code:</u> 0 = no pain 5 = moderate pain 10 = worst possible pain</p> <hr/> <p>Select one. 0 1 2 3 4 5 6 7 8 9 10</p>

HEALTH MAINTENANCE

Please record when you last received or completed the following items. If never or not applicable, write N/A.

Hepatitis B	_____	Hearing Exam	_____
Flu Vaccine	_____	Alcohol Cessation	_____
Pneumonia Vaccine	_____	Smoking Cessation	_____
Tetanus Vaccine	_____	Nutrition Therapy	_____
Shingles Vaccine	_____	Diabetic Education	_____
Glucose	_____	A1c (Diabetic Only)	_____
Aneurysm Screen	_____	Mammogram (Female)	_____
Bone Density Scan	_____	Pap Smear (Female)	_____
Colonoscopy	_____	Pelvic Exam (Female)	_____
Lipid Panel	_____	Prostate Exam (Male)	_____
Eye Exam	_____	PSA Test (Male)	_____
Echocardiogram	_____	Rectal Exam (Male)	_____