



Today's Date: _____

NAME: _____ Date of Birth: _____

Please list other medical specialists you see regularly:

Ex. Cardiology, Pulmonologist, Nephrologist (Kidney), Urologist, Orthopedist, Rheumatologist, Physical Therapist, Podiatrist, Chiropractor, Acupuncturist, Massage Therapist, Nutritionist, Naturopath, Dentist, Optometrist/Ophthalmologist, Neurologist, Gynecologist, Psychiatrist, Psychologist, Counselor, Oncologist.

Name	Facility/Clinic & City Phone #	Specialty

EMERGENCY CONTACTS

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

ADVANCED DIRECTIVES

Do you have a living will or healthcare directive? **Y N**

Do you have a DPOA (durable power of attorney) for healthcare? **Y N**

If yes, who is it? _____

HEALTH AND SAFETY QUESTIONS

Have you had any major changes in your life this past year? **Y N**

Please explain: _____

Do you have any vision difficulties? **Y N**

Name and location of eye doctor (optometrist or ophthalmologist):

Last visit: _____



Do you have any tooth or oral problems that interfere with eating? Y N

Do you wear dentures? Y N

Name and location of dentist: _____

Last visit: _____

Do you have any hearing difficulties? Y N Do you wear hearing aids? Y N

Do you have any speech difficulties? Y N

Do you have any Sleep pattern/difficulties? Y N

How many hours of sleep do you get every night? _____

Do you have any Urinary difficulties or incontinence? Y N

Do you have any Bowel difficulties? Y N

Do you have any difficulties walking? Y N

Have you fallen in the last year? Y N

Do you have any concentration or memory problems? Y N

Do you drive? Y N Do you think you are a safe driver? Y N

Do you feel safe at home? Y N Do you have adequate housing? Y N

Do you have sufficient heat? Y N Do you have sufficient food? Y N

Do you have working smoke and carbon monoxide detectors? Y N

If you have guns in the home are they secured/locked? Y N N/A

Do you regularly use seatbelts/helmets? Y N

Are you experiencing physical, emotional, financial or sexual abuse? Y N

Circle or Mark with an X those things you CANNOT do on your own:

Bathing and hygiene self-care

Dressing

Shopping for groceries or clothing

Meal preparation and cleanup

Eating and Drinking

Taking medications

Health maintenance and management

Housework

Community mobility – getting around town

Managing money

Using technology and telephone

Care of pets

Care of others (including supervising caregivers)



MEDICAL QUESTIONS

Please list **ALL MEDICAL DEVICES** you use.

Ex. Wheelchair, walker, cane, prosthesis, CPAP, oxygen, TENS machine

Device	Details	Why?

Last Colon Cancer Screening: Colonoscopy Cologard FIT test
 Date: _____ Result: _____

Last Bone Density Exam (DEXA): _____

Results: Normal **Osteopenia** **Osteoperosis** **Don't Know**

Do you take Vitamin D? Y **N** What dose & how often? _____

Do you take Calcium? Y **N** What dose & how often? _____

Do you take any other medicine for bone health/strength? Y **N**
 What, how much, & how often? _____

Have you ever broke a bone? Y **N** Explain: _____

VACCINES – Enter year (if known) of vaccinations you have had.

Tetanus (Td or TdaP) _____ Influenza (Flu) _____

COVID _____ circle: Moderna Pfizer J&J/Janssen

Pneumococcal: (PPSV23) _____ (PCV13) _____

Shingles: Zostavax (newer 1-dose) _____ Shingrix (older 2-dose) _____

PERSONAL/SOCIAL QUESTIONS

Who do you live with? _____

Marital Status: Single Married Divorced Widow/Widower

Spouse's Name: _____ How many children do you have? _____ Do any live nearby? Y **N**

Do you have any pets? Y **N** Details: _____

Do you have a support circle? Family, friends, work, volunteer, church, etc... Y **N**

What are your hobbies, what do you do in your spare time? _____



During the past 2 weeks:

Have you been bothered by feeling down, depressed or hopeless? Y N

Have you been bothered by little interest or pleasure in doing things? Y N

Circle the type of diet you follow: Regular Vegetarian Vegan Gluten Free Mediterranean Keto

Other: _____

Do you eat 2 or more meals daily? Y N

How many fruits and vegetables do you eat daily? _____

How many days per week to you do moderate exercise, like gardening or going for a brisk walk? _____

What type of exercise do you do and how often? _____

Do you drink alcohol? Y N

What type & how much/often? (ex. 1 glass wine nightly, 6 pack every Saturday) _____

Do you use tobacco? Y N

What type (smoking, vaping, chewing, snuff) and how much/often? (ex. 1/2 pack per day, tin of chew weekly): _____

Do you use marijuana products ? Y N

What type (CBD or THC, topical, edible, vape, smoke, pills) and how much/often? _____

Do you ingest caffeine daily? Y N

If so, how much and of what? _____

Do you take opiates (vicodin, hydrocodone, tramadol, codeine, fentanyl, oxycodone, heroin)? Y N

Do you take any stimulants (Adderall, Ritalin, Methamphetamine)? Y N

Do you take any sedatives like barbiturates, benzodiazepines or hypnotics (sleep medications)? Y N

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Do you use any recreational drugs? Y N

What type and how much/often? _____

Are you sexually active? Y N With men, women or both? _____

Do you practice safe sex (monogamy or using condoms)? Y N

Are you worried you might currently have an STI? Y N

Do you feel safe in your relationship? Y N

Does your partner ever hit you, threaten you or force you to have sex? Y N

Does your partner(s) use IV drugs? Y N

Do you have any sexual problems or concerns you'd like to discuss? Y N

MEN ONLY

Have you ever had problems with your prostate? Y N

How strong is your urine stream? Strong Okay Weak Varies

Do you ever dribble urine or are you ever incontinent? Y N

Do you ever have pain when urinating? Y N

Do you ever see blood in your urine? Y N

Do you ever have trouble getting an erection? Y N

Do you ever have problems with ejaculation (difficulty, pain, blood)? Y N

Have you ever had an elevated PSA blood test? Y N

WOMEN ONLY

Age at menopause (last period ever)? _____

Have you had any bleeding since menopause? Y N

Have you had a hysterectomy? Y N When? _____

Since menopause have you taken or used estrogen and/or progestin? Y N

Are you currently taking or using estrogen and/or progestin? Y N

Last pap: _____ Results: Normal Abnormal Don't know

Have you ever had an abnormal pap? Y N

Please explain: _____

Have any of your relatives had ovarian cancer? Y N

Do you have any vaginal complaints? Y N



Please explain: (pain, itching, swelling, discharge, etc...):

Last Mammogram: _____ Results: Normal **Abnormal** **Don't know**

Have you ever had an abnormal mammogram? **Y** **N**

Please explain: _____

Have any of your relatives had breast cancer? **Y** **N**

Do you have any breast complaints? **Y** **N**

Please explain: (pain, lumps, rashes, nipple changes, etc...): _____
