Preventive and Problem Visits

Important information about charges and payments

If you are expecting to have a fully covered wellness exam only, please bring this to the attention of your practitioner at the beginning of your visit.

We practitioners often deal with, and patients often ask us to address, chronic or new problems while they are here for their preventive care/wellness visits. Usually most patients don't want to come back for another visit if their problems can be addressed while they are in the office.

In that case, we must charge for a wellness exam and a diagnostic exam on the same visit and patients must pay any co-pays or deductibles due for the diagnostic exam charge. Insurance policies require this. If the practitioner does not have time to deal with all the problems you bring up then they will ask you to schedule another visit.

We do our best to address all your needs while you are here but **if you do not want any charges for a diagnostic exam you must tell the practitioner at the beginning of your visit to only deal with preventive care** so they are aware of your wishes. If you have any chronic problems and/or identified symptoms that need attention the practitioner will then ask you to schedule a separate appointment at another time so as to limit the charges to just a wellness visit.

NAME **DATE OF BIRTH** **AGE** **APPOINTMENT DATE**

In order for us to provide you with effective medical care, we need to update some basic information about your past and present health. We also need to ask about your lifestyle because it affects your physical and emotional well being. The questions on the next pages cover the topics we will discuss. Please answer them as best you can. Mark an X on the line following the word "No" or"Yes" when either describes your symptoms or history. Use a question mark when you don't understand a question or aren't sure of your answer.
Please remember to put your name and date of birth on all pages. Thank you for completing this form.

Before you start, please list all questions you have for the doctor:

Since your last visit have you had urgent care or a change in health? no ____ yes ____
If yes, what was it?

Has there been a change in the health of your mother, father, sisters, brothers, spouse, or children? no ____ yes ____
if yes, what was the change?

Please list all the medicines, tonics, and over-the-counter medicines, vitamins and supplements you take:
(use a separate sheet if needed)

Name	strength	how often	for what

PLEASE BRING ALL YOUR BOTTLES OF MEDICATION TO EACH APPOINTMENT

Do you have any allergies to medications? Please list them and describe your reaction:

Which is your dominant side? (which hand do you write with?) Right Left

During the past year, have you:

1	had any falls?	no ____	yes ____
2	had frequent headaches?	no ____	yes ____
3	felt dizzy, fainted or had blackouts?	no ____	yes ____
4	had seizures or convulsions?	no ____	yes ____
5	noticed any lumps on your body or swollen glands?	no ____	yes ____
6	had eye trouble?	no ____	yes ____
7	had difficulty hearing?	no ____	yes ____
8	had troubles with your ears?	no ____	yes ____

NAME **DATE OF BIRTH**

9	had dental or other mouth problems?	no	____	yes	____
10	suffered from nose bleeds?	no	____	yes	____
11	suffered from allergies or hay fever?	no	____	yes	____
12	noticed any hoarseness in your voice?	no	____	yes	____
13	been wheezing or been short of breath?	no	____	yes	____
14	had strange, persistent odors or tastes?	no	____	yes	____
15	frequently been coughing?	no	____	yes	____
16	sweated more than usual or had "night sweats"?	no	____	yes	____
17	had a racing heart or palpitations?	no	____	yes	____
18	had tightness or pains in your chest?	no	____	yes	____
19	had swollen feet or ankles?	no	____	yes	____
	During the past year, have you had:				
20	heartburn or indigestion?	no	____	yes	____
21	abdominal discomfort or pain?	no	____	yes	____
22	bouts of nausea or vomiting?	no	____	yes	____
23	difficulty swallowing?	no	____	yes	____
24	pains in your rectum?	no	____	yes	____
25	bowel movements that were bloody or tarry (dark red or black in color)?	no	____	yes	____
26	any change in your bowel habits?	no	____	yes	____
27	If you are over 50, have you ever had a sigmoidoscopy or colonoscopy?	no	____	yes	____
	If yes, when? Where? Results?				
28	frequent urination during the day or at night?	no	____	yes	____
29	uncomfortable or difficult urination?	no	____	yes	____
	For Men Only: During the past year, have you:				
30	had a drip or discharge from your penis?	no	____	yes	____
31	noticed lumps or swellings on your testicles?	no	____	yes	____
32	had difficulty with your erection?	no	____	yes	____
	For Women Only:				
	Do you have any 1st or 2nd degree relatives who have had breast &/or ovarian cancer?	no	____	yes	____
	If yes , please list relationship to you,type of cancer, & at what age were they diagnosed				
	If you are past your menopause, please skip to question 39				
33	When was your last menstrual period?				
34	Was it normal?	yes	____	no	____
35	Number of days between periods				
36	Length of bleeding, in days				
37	Has there been any change in your periods?	no	____	yes	____
38	Have you noticed bleeding between your periods?	no	____	yes	____
39	Do you have discomfort during intercourse?	no	____	yes	____
40	Do you bleed from your vagina after intercourse?	no	____	yes	____
41	Do you have any vaginal itching, burning or discharge?	no	____	yes	____
42	- discomfort or pain in your pelvis?	no	____	yes	____
43	- problems with your breasts?	no	____	yes	____

NAME **DATE OF BIRTH**

44	When was your last Pap test?					
45	Where was it done?	Was it normal?		yes	no	
46	Have you ever had an abnormal Pap test?			no	yes	
47	Have you ever had a mammogram?			no	yes	
	Date of last mammogram:					
48	Where was it done?					
49	Was it normal?			yes	no	
	For Women aged 50-64 Only:					
49	As an adult, have you had a fracture from relatively mild trauma?			no	yes	
50	Did either of your parents have a hip fracture?			no	yes	
51	Do you smoke?			no	yes	
52	Have you been on prednisone or other 'steroid' medication in the past?			no	yes	
53	Have you ever been diagnosed with Rheumatoid Arthritis?			no	yes	
54	On average, do you have 3 or more servings of alcohol per day?			no	yes	
55	Have you ever had any of the following (if yes, please circle any that apply):			no	yes	
	Type 1 Diabetes, osteogenesis imperfecta, hyperthyroidism, hypogonadism,					
	menopause prior to age 45, chronic liver disease, malabsorption or chronic malnutrition?					
	For Both Men and Women, During the past year have you:			no	yes	
56	had any skin problems or noticed any changes in your skin or glands?			yes	no	
57	had aching muscles or joints?			no	yes	
58	had leg cramps?			no	yes	
59	Do you use sunscreen routinely?			no	yes	
	Eating, Drinking, and Environmental:					
60	Have you gained/lost 10 or more pounds in the past 6 months?			no	yes	
61	Do you drink caffeinated coffee, tea or soda?			no	yes	
62	On average how much caffeinated coffee, tea or soda do you drink per day?					
63	On average how much non-caffeinated soda do you drink per day?					
64	On average how much Juice do you drink per day?					
65	On average, how many servings of Fruits and Vegetables do you eat per day?					
66	Do you smoke or use tobacco products now?			no	yes	
67	If you smoke, how many years have you been smoking?					
68	On average, over the years, how much have you smoked per day?					
69	If you don't smoke, have you quit in the last 15 years?			no	yes	
70	If you stopped some time ago, when was it?					
71	Are you or have you used prescription drugs without having a prescription?			no	yes	
72	Are you or have you ever used "recreational" drugs?			no	yes	
73	Have your pets been vaccinated for rabies?			yes	no	
74	Do you have a Living Will and Health Care Proxy filed with us?			yes	no	
	Work and Play:					
75	Are you generally satisfied with your work?			yes	no	
76	What kinds of exercise do you do?					
77	What are your hobbies or leisure activities?					

NAME **DATE OF BIRTH**

78 In what kinds of groups, organization, or community activities do you participate?

79 List the countries that you have visited in the past 6 months

80	Do you usually wear safety belts when riding in a car?	yes		no	
81	Are there smoke detectors in your house that work?	yes		no	
	Sexuality:				
82	Are you sexually active now?	yes		no	
83	Are you generally satisfied with sex?	yes		no	
84	What do you do for family planning or birth control?				
85	Do you have sexual concerns?	no		yes	
86	In the last 5 years how many sexual partners have your had?				
87	Would you like an HIV test?	no		yes	
88	Do you use or have contact with anyone who uses IV drugs?	no		yes	
	Family Apgar Assessment				
	"Family" here refers to the relatives or close friends with whom you usually live or look to for continuing emotional support.				
	Are you satisfied with the way your family:				
89	- helps you when you are in trouble?	yes		no	
90	- discusses things and shares your problems?	yes		no	
91	- accepts your new interests or changes in your lifestyle?	yes		no	
92	- expresses affection and responds to your feelings or moods?	yes		no	
93	- spends time together with you?	yes		no	
94	Are you concerned about physical violence or possible incest in your family?	no		yes	
	Social Support				
95	Is your time well balanced between your work, family, and leisure activities?	yes		no	
96	Is your relationship with your friends as good as it was last year?	yes		no	
97	Is your relationship with your spouse/partner as good as it was last year?	yes		no	
98	Is there someone with whom you can always discuss your personal problems?	yes		no	
99	Do you ever feel unsafe at home?	yes		no	
100	Has anyone at home hit or tried to injure you in any way?	yes		no	
101	Would you like patient education on any topics?	no		yes	
102	What topics?				

Dryden Family Medicine
PHQ-9 + CAGE-AID

	Patient Name	Date of Birth			Today's Date	
	PHQ-9					
	Over the Past 2 weeks, how often have you been bothered by any of the following problems?	Not at All	Several days	More than half the days	Nearly every day	
1	Little Interest or pleasure in doing things	0	1	2	3	
2	Feeling down, depressed or hopeless	0	1	2	3	
3	Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3	
4	Feeling tired or having little energy	0	1	2	3	
5	Poor Appetite or overeating	0	1	2	3	
6	Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3	
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	
8	Moving or speaking so slowly that other people have noticed; or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3	
9	Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3	
	Column Totals					
	Add totals together					
10	If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other	Not difficult at all	Some-what Difficult	Very Difficult	Extremely Difficult	

	CAGE-AID				NO = 0	YES = 1
1	Have you ever felt you ought to cut down on your drinking or drug use?					
2	Have people annoyed you by criticizing your drinking or drug use?					
3	Have you felt bad or guilty about your drinking or drug use?					
4	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?					
5	How many times have you had more than 5 drinks in the past year?					
	rev 03/2019			**Column Totals**		

Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol/drug problems.
A total score of two or greater is considered clinically significant