MSA FAMILY MEDICINE

Patient Account Number

Patient History

Patient Name________________________________ D.O.B.

Medication AllergiesPrimary Care

____

Provider

________________________________ __________________

Hospitalized

Illnesses/injuries/operations/diagnoses since last physical exam Date

Medications or supplements name	Route (Oral, Topical, etc.)	Dose	Frequency (1 time daily)

Do you currently see any other specialists/physicians outside of our office?

Name	Specialty	Reason

Continue to the next page below

Patìent History conto

Patient Account Number

Family History

Mother	Alive Deceased	Age	Cancer ____ Heart Disease ____ Diabetes ____ Other ____
Father	Alive Deceased	Age	Cancer ____ Heart Disease ____ Diabetes Other
Sister(s)	Alive Deceased Alive Deceased	Age Age	Cancer ____ Heart Disease ____ Diabetes ____ Other ____
Brother(s)	Alive Deceased Alive Deceased	Age Age	Cancer ____ Heart Disease ____ Diabetes Other
Children	Alive Deceased Alive Deceased	Age Age	Cancer ____ Heart ____ Disease Diabetes Other

Tobacco use: Yes____ No____If yes, (smoke or chew) how many packs daily?

______

Alcohol use: Yes ____ ____ No If yes, what do you typically drink and how many times in the past year have you had 4 or more drinks in a day? 1 or more None

______ ____ ____

Drug use: ____ ____ ______________ Yes No If yes, what drug?How many times in the past year have you used a recreational drug or prescription drug for nonmedical reasons?

1 or more None

____ ____

Do you have trouble hearing the TV or Radio when others don't? YES____ No

____

Do you have to strain to hear/understand conversations? YES ______ No ______

Do you need help with preparing meals, transportation, shopping, taking your meds, managing finances, or other activities of daily living? YES______ No ______

Do you live alone? YES______ No______

Have you had any falls in the last year? YES______ No ______

Do you have any trouble with memory loss? YES______ No______

Have you had more than one fall in the last year? YES No Have you had an injury from a fall in the last year? YES No

Does your home have rugs, poor lighting, or a slippery bathtub/shower? YES ______ No ______

Does your home LACK grab bars in the bathroom, handrails on stairs/steps? YES ______ No ______

Does your home LACK functioning smoke alarms? YES ______ No ______

Advanced care planning

Patient Consent if applicable: "I consent to discuss end-of-life issues with my healthcare provider."

Patient/Guardian Signature ______________________ Date ______________________

Generalized Anxiety Disorder 7-item (ÇADû) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all •sure	Several days	Over half the days	Nearly every day
1. Feeling anxious, or on edge		1	2	3
2. Not being able to stop or control worrying		1	2	3
3: Worrying-too much about different things		1	2	3
4. Trouble relaxing		1	2	3
5, Being so restless that it's hard to sit still	0	1	2	3
6. Becoming' easily annoyed or		1	2	3
7. Feeling afraid as if something awful might happen		1	2	3
—Add-the score far each column				
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all__________
Somewhat difficult __________
Very difficult __________
Extremely difficult__________

Source: Spitzer RL, I<xoenke K, Williams JBW, Lowe B, A brief measure for assessing generalized anxiety disorder. Arch Inern Med.2006:166:1

PATHENT HEALTH QUESTIONNAIRE (PHQO)

DATEa

Over the•'last 2 weeks, how often have you been bothered by any of the following problems? (use to-indicate your answer)	Not at all	Several days	More than half the	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
5. •Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down			01	
Trouble concentrating on things, such as reading the newspaper or watching television				
8M Moving or speaking so slowly that other people could have noticed. Or the opposite—being so figety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself				

add columns

(Healthcare professional: For interpretation of TOTAL, TOTAL: please refer to accompanying scoring card).

'10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at ail Somewhat difficult' Very difficult Extremely difficult

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