

Primary Care Physician Name: _____

Social History										
Alcohol use:										
Tobacco use:										
Illicit drug use:										
Diet/physical activities:										
Depression Screen										
Over the last 2 months, have you been bothered by the following:			Yes	No						
Little interest or pleasure in doing things?			<input type="checkbox"/>	<input type="checkbox"/>						
Feeling down, depressed, or hopeless?			<input type="checkbox"/>	<input type="checkbox"/>						
Trouble falling or staying asleep?			<input type="checkbox"/>	<input type="checkbox"/>						
Poor appetite or overeating?			<input type="checkbox"/>	<input type="checkbox"/>						
Trouble concentrating?			<input type="checkbox"/>	<input type="checkbox"/>						
Functional Ability/Safety Screen										
			Yes	No						
Does your home have handrails, grab rails, adequate lighting?			<input type="checkbox"/>	<input type="checkbox"/>						
Does your home have hallway rugs or floor coverings that have frayed corners or rolled edges?			<input type="checkbox"/>	<input type="checkbox"/>						
Is it difficult to get on and/or off the toilet?			<input type="checkbox"/>	<input type="checkbox"/>						
Do you need assistance with eating, bathing, dressing, personal hygiene, or housekeeping?			<input type="checkbox"/>	<input type="checkbox"/>						
Hearing Evaluation:		Number of falls in the past year:								
Problem List <small>(All abnormal findings should be detailed below)</small>										
Education/Counseling/Referral for Other Preventive Services										
Service	Ordered/Schedule	Date of Last Exam	Education/Counseling/Recommendations/Referrals							
Zosta Vaccine	<input type="checkbox"/>	_/_/___								
Pneumococcal Vaccine	<input type="checkbox"/>	_/_/___								
Influenza Vaccine	<input type="checkbox"/>	_/_/___								
Hepatitis B Vaccine	<input type="checkbox"/>	_/_/___								
Mammogram	<input type="checkbox"/>	_/_/___								
Pap Test and Pelvic Examination	<input type="checkbox"/>	_/_/___								
Prostate Cancer Screening	<input type="checkbox"/>	_/_/___								
Colorectal Cancer Screening	<input type="checkbox"/>	_/_/___								
Diabetes: HgA1C	<input type="checkbox"/>	_/_/___								
Diabetes: Micro Albumin	<input type="checkbox"/>	_/_/___								
Bone Density	<input type="checkbox"/>	_/_/___								
Hypertension, Coronary Artery Disease	<input type="checkbox"/>	_/_/___								
Other Counseling/Education Provided										
<input type="checkbox"/> Diet:		<input type="checkbox"/> Exercise:								
<input type="checkbox"/> Fall Prevention:		<input type="checkbox"/> Stroke Prevention:								
<input type="checkbox"/> Vitamins/Supplements:		<input type="checkbox"/> Other:								
Pain Evaluation Management										
Pain Level <small>(1 being no pain and 10 being severe)</small>	1	2	3	4	5	6	7	8	9	10
Pain Treatment:										
Current treatment:										



Physician/Provider Signature _____

Primary Care Physician Name: _____

Name: _____ DOB: ____/____/____ Today's Date ____/____/____

Past Medical History

Illness/Injury/Surgery	Date	Hospitalized?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Current Medications:

Allergies:

Supplements including calcium and vitamins:

Med. Review / Date:

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Family History (Mother, Father, Sibling, Grandparent)

Family Member	Living	Deceased	Age	Cause of Death

Disease	Mother	Father	Sibling	Grandparent
Cancer (list type below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Disease/MI/CHF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (Please list) _____



Physician/Provider Signature _____