MOUNTAIN VIEW
INTERNAL MEDICINE & PEDIATRICS

What you should bring to your Annual Wellness Visit:

The names of all your doctors:

Name	Specialty

A list of all your medications

Name of medicine	Dose (if you remember)

Have any of your close relatives had any health changes? ____Yes ____No

Has your mood changed? ____Yes ____No

Do you worry about falling? ____Yes ____No

Are you worried about your memory? ____Yes ____No

Are there any preventive tests you have done recently? (such as lab tests, mammograms, x-rays) ____Yes ____No

Have you had any recent immunizations? (Please bring copy of previous vaccines with you.) ____Yes ____No

Do you have a living will or advance directive? ____Yes ____No
(If you have one, *please bring a copy of it with you*.)

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Patient Health Questionnaire for Depression Screening

Patient Name:_____ Date:_____
Date of Birth: _____

Over the past two weeks, how often have you been bothered by any of the following problems? **(circle the number to indicate your answer)**	Not at all	Several days	More than one half of 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 or 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 are 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 could 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 thoughts of hurting yourself	**0**	**1**	**2**	**3**
add columns:		_____	_____	_____
Total:_____				

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 all
Somewhat difficult
Very difficult
Extremely difficult

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ADULT HEALTH HISTORY

Name: _____ _____ _____
Last First Middle

Age ____ Date of Birth _____ Date of last physical exam _____

What is the reason for today's visit _____ ____

SYMPTOMS – Check (✓) symptoms you currently have or have had in the past year

GENERAL
___ Chills
___ Depression
___ Dizziness
___ Fainting
___ Forgetfulness
___ Headaches
___ Loss of Sleep
___ Loss of weight
___ Nervousness
___ Numbness
___ Sweats

MUSCLE\JOINT\BONE
Pain, weakness, numbness in:
___ Arms ___ Hips
___ Back ___ Legs
___ Feet ___ Neck
___ Hands ___ Shoulders

GENITO-URINARY
___ Blood in urine
___ Frequent urination
___ Lack of bladder control
___ Painful urination

GASTROINTESTINAL
___ Appetite poor
___ Bloating
___ Bowel Changes
___ Constipation
___ Diarrhea
___ Excessive hunger
___ Excessive thirst
___ Gas
___ Hemorrhoids
___ Rectal bleeding
___ Stomach pain
___ Vomiting
___ Vomiting blood

CARDIOVASCULAR
___ Chest pain
___ High blood pressure
___ Irregular heart beat
___ Low blood pressure
___ Rapid heart beat
___ Poor circulation
___ Swelling of ankles
___ Varicose veins

EYE, EAR, NOSE, THROAT
___ Bleeding gums
___ Blurred Vision
___ Crossed eyed
___ Difficulty swallowing
___ Double Vision
___ Earache
___ Ear discharge
___ Hay Fever
___ Hoarseness
___ Loss of hearing
___ Nosebleeds
___ Persistent cough
___ Ringing in the ear
___ Sinus problems
___ Vision – Flashes
___ Vision – Halos

SKIN
___ Bruise easily
___ Hives
___ Itching
___ Changes in moles
___ Rash
___ Scars
___ Sore that won't heal

MEN ONLY
___ Breast lump
___ Erection difficulties
___ Lump in testicles
___ Penis discharge
___ Sore on penis
___ Other

WOMEN ONLY
___ Abnormal Pap Smear
___ Bleeding between periods
___ Breast lump
___ Extreme menstrual pain
___ Hot flashes
___ Nipple discharge
___ Painful intercourse
___ Vaginal discharge
___ Other
Date of last
Menstrual period _____
Date of last
Pap Smear _____
Have you had
a mammogram? _____
Are you pregnant? _____
Number of children _____

CONDITIONS – Check (✓) diagnoses you currently have or have had in the **past year**

___ AIDS
___ Alcoholism
___ Anemia
___ Anorexia
___ Appendicitis
___ Arthritis
___ Asthma
___ Bleeding disorders
___ Breast lump
___ Bronchitis
___ Bulimia
___ Cancer
___ Cataracts
___ Chicken Pox
___ Diabetes
___ Emphysema
___ Epilepsy
___ Glaucoma
___ Goiter
___ Gout
___ Heart Disease
___ Hepatitis
___ Hernia
___ Herpes
___ High Cholesterol
___ HIV positive
___ Kidney disease
___ Liver disease
___ Measles
___ Migraine headaches
___ Miscarriage
___ Mononucleosis
___ Multiple Sclerosis
___ Mumps
___ Pacemaker
___ Psychosocial Issues
___ Pneumonia
___ Polio
___ Prostate problems
___ Psychiatric care
___ Rheumatic Fever
___ Scarlet Fever
___ Stroke
___ Suicide attempt
___ Thyroid problems
___ Tonsillitis
___ Tuberculosis
___ Ulcers
___ Vaginal infections
___ Venereal disease

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FAMILY HEALTH HISTORY – Fill in health information about your immediate family.

Relation	Age	State of Health	Age of Death	Cause of Death	Check (✓) if, your blood relatives had any of the following. Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical dependency	
					Diabetes	
					Heart disease, Strokes	
Sisters					High blood pressure	
					Kidney disease	
					Tuberculosis	
					Other	

HOSPITIZATIONS Year	Hospital	Reason for Hospitalization and outcome

PREGNANCY HISTORY Year of birth	Sex of birth	Complications, if any

Have you ever had a blood transfusion? ____ Yes ____No

If yes, please give approximate dates _____

SERIOUS ILLNESS\INJURIES	**DATE**	

HEALTH HABITS – check (✓) which substances you use and describe how much you use:

	Exercise	
	Diet	
	Caffeine	
	Tobacco	
	Alcohol	
	Street Drugs	
	Other	

MEDICATIONS – List medications you are currently taking	**ALLERGIES** (medications or substances)

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