Stillwater Medical
Clinics

HOW CAN WE HELP YOU TODAY?

PATIENT NAME IN FULL	DATE OF BIRTH

Please help us understand the reason for today's appointment so that we can meet your needs. ***Please select one only***

☐ **Preventive Exam (Wellness visit/Complete physical)**

- Done to promote health and wellness
- May include discussion of screening tests (i.e. mammograms, colonoscopies)
- Discuss need for immunizations and/or labs based on guidelines appropriate for for age/gender

☐ **Illness/problem-focused visit (Wellness exams do NOT cover this type of visit)**

- Follow up on existing medical problem(s) to help assure appropriate treatment
- New or existing symptoms
- New illnesses or injuries

Because of the many differences among policies, we cannot advise you about your particular policy. If you have questions about your benefits, please call the phone number on the back of your card.

PATIENT SIGNATURE	DATE

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Patient Name: _____ Date of Birth: _____

Healthcare Update Form - Please note any changes/updates from other physicians we may not be aware of:

1. In the last year, have you developed any new problems? _____

_____

2. In the last year, have you had any surgeries or hospitalizations? _____

_____

3. Have you had any imaging studies (CT, MRI, cardiac testing, etc.)? _____

_____

4. In the last year, have any family members (parents, siblings, or children) been diagnosed with a chronic illness? If so, please list: _____

_____

5. Please list any specialists you see: _____

_____

6. Please list changes to your medications: _____

_____

7. Please list changes to your drug allergies: _____

_____

REVIEW OF SYSTEMS - Please check "Yes" if you had the symptom recently:

Yes

CONSTITUTIONAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weight gain
- ☐ Weight loss

HEENT
- ☐ Ear drainage
- ☐ Ear pain
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Nasal drainage
- ☐ Sinus pressure
- ☐ Sore throat
- ☐ Vision changes

RESPIRATORY
- ☐ Chronic cough
- ☐ Cough
- ☐ Known TB exposure
- ☐ Shortness of breath
- ☐ Wheezing

Yes

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Leg cramps
- ☐ Edema
- ☐ Palpitations

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Change in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Excessive urination
- ☐ Urinary frequency
- ☐ Urinary incontinence
- ☐ Urinary retention

Yes

REPRODUCTIVE
BIRTH FEMALE
- ☐ Abnormal Pap
- ☐ Painful periods
- ☐ Painful intercourse
- ☐ Hot flashes
- ☐ Irregular menses
- ☐ Vaginal discharge

REPRODUCTIVE
BIRTH MALE
- ☐ Erectile dysfunction
- ☐ Penile discharge
- ☐ Sexual dysfunction

INTEGUMENTARY
- ☐ Breast discharge
- ☐ Breast lump
- ☐ Brittle hair
- ☐ Brittle nails
- ☐ Hair loss
- ☐ Excessive hairiness
- ☐ Hives
- ☐ Itching
- ☐ Mole changes
- ☐ Rash
- ☐ Skin lesion

Yes

NEUROLOGICAL
- ☐ Dizziness
- ☐ Extremity numbness
- ☐ Extremity weakness
- ☐ Gait disturbance
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

METABOLIC & ENDOCRINE
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger

Yes

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Neck pain

HEMATOLOGIC & LYMPHATIC
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen lymph glands

IMMUNOLOGIC
- ☐ Contact allergy
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Seasonal allergies

Stillwater Medical
PHYSICIANS CLINIC

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Tobacco

Have you ever used tobacco? No/never _____ Yes _____ If yes, type: _____

Years used: _____ Age started: _____ Age stopped: _____

Have you ever tried to quit? No/never _____ Yes _____ When? _____

Alcohol

Do you drink alcohol? No _____ Yes _____ Formerly _____

If yes, type: _____ Frequency: _____ Amount: _____

Caffeine

Do you drink/consume caffeine? No _____ Yes _____

If yes, type: _____ Caffeine per day: _____

THC

Do you use THC products? No _____ Yes _____ Type _____

FAMILY HISTORY

Condition	Relation	Condition	Relation	Condition	Relation
☐ ADD/ADHD		☐ CAD, premature		☐ Kidney disease	
☐ Alcoholism		☐ Depression		☐ Learning disability	
☐ Allergies		☐ Developmental delay		☐ Mental disorder	
☐ Alzheimer's disease		☐ Diabetes		☐ Migraines	
☐ Arthritis		☐ Eczema		☐ Obesity	
☐ Asthma		☐ Genetic disease		☐ Osteoporosis	
☐ Blood disorder		☐ Hearing loss		☐ Peripheral disease	
☐ Cancer		☐ High cholesterol		☐ Seizure disorder	
☐ Cardiovascular disease		☐ High blood pressure		☐ Stroke	
☐ Coronary artery disease		☐ Bowel disease		☐ Thyroid disorder	

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**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 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 of hurting yourself in some way.	0	1	2	3

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? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3

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? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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