Mesa Family Physicians

For in-office use only
Chart #_____

PATIENT HISTORY QUESTIONNAIRE

Name:_____ **DOB:**_____ **Date:**_____

Preferred Communication: Cell phone # _____ (or) Home **#**_____

Gender: _____ **Preferred Language:** English / Spanish / Other **Marital Status:** _____

Race: Caucasian / Asian / Latino / African American / Other_____

Pharmacy Name & Number: _____

Medications: YES (list meds/over the counter supplements below)
No (I do not take medications or over the counter supplements)

Please list **ALL** the medications you take, including over the counter drugs or supplements.

Name of Medicine	Dosage & How often taken	Reason for taking this med

Allergies: Yes (list below) No Allergies

List all Allergies - such as food, medications, chemicals, etc.

Allergy	Reaction

Doctors: Please list all doctors currently involved in your care.

Name	Phone #	Reason

Mesa Family Physicians

For in-office use only
Chart #_____

Name: _____ **DOB:** _____ **Date:** _____

Family History: Please check box for past or present conditions.

Medical Problems	Mother	Father	Siblings	Grandparents
High Blood Pressure				
Lung Disease				
Bleeding Problems				
Diabetes				
Stroke				
Heart Disease				
Cancer				
Other				

____ Medical History Entered Above ____ I have no prior medical history of the above conditions

Past Medical History – Diagnosed: Check all that apply

☐ High Blood Pressure	☐ Bleeding Disorder	☐ Hepatitis B or C
☐ Atrial Fibrillation	☐ COPD/Chronic Bronchitis	☐ Anemia
☐ Asthma	☐ Diabetes	☐ Infections
☐ Sleep Apnea	☐ Stroke	☐ Bowel Disease
☐ Acid Reflux	☐ Kidney Problems	☐ Rheumatic Fever
☐ Heart Disease	☐ DVT	☐ Seizures
☐ High Cholesterol	☐ HIV	☐ Thyroid Disease
☐ Gout	☐	☐
☐ Cancer (please write in):	Any Mental Illness: ☐ Depression ☐ Bipolar ☐ Anxiety ☐ Other	☐ Other medical problems not listed:

Past Surgical, Hospitalization & Injury History: Please list all surgeries, hospitalizations & injuries and the dates they were performed. (If none, please write N/A).

☐ Hysterectomy	☐ Tonsils/Adenoids	☐ Gall Bladder
☐ Ovaries removed? yes / no	☐ Muscle/Joint surgeries	☐ Colonoscopy
☐ Appendix	☐ Cataracts	☐
☐ Any Biopsies? (please list) _____ _____	☐ Other (explain) _____ _____	_____ _____

Personal Social History:

Tobacco Use: (never) (quit/when: _____) (current smoker/ _____ packs a day)
Alcohol Use: (never) (rarely) (moderate) (daily) How Much? _____
Drug Use: (never) Type/Frequency:_____

Occupation:_____

Mesa Family Physicians

For in-office use only
Chart #_____

Name:_____ **DOB:**_____ **Date:**_____

Review of Systems: (Please circle yes or no)

General/Constitutional:
Weight Gain? Yes / No
Weight Loss? Yes / No
Fever? Yes / No
Fatigue? Yes / No
Change in Appetite? Yes / No
Night Sweats? Yes / No

Ophthalmologic:
Blurred double vision? Yes / No
Glasses/contacts? Yes / No
Glaucoma? Yes / No
Eye/Disease/Injury? Yes / No

ENT:
Ringing in ears? Yes / No
Sore throat? Yes / No
Sinus problems? Yes / No
Decreased hearing? Yes / No
Nosebleed? Yes / No

Cardiovascular:
Chest pain at rest? Yes / No
Chest pain w/exertion? Yes / No
Palpitations? Yes / No
Heart trouble? Yes / No
Fluid accumulation in legs? Yes / No

Respiratory:
Shortness of breath? Yes / No
Shortness of breath w/ exertion? Yes / No
Wheezing/Asthma? Yes / No
Coughing up blood? Yes / No

Endocrine:
Excessive thirst? Yes / No
Thyroid disease? Yes / No
Hormone problem? Yes / No

Musculoskeletal:
Leg cramps? Yes / No
Muscle aches? Yes / No
Joint stiffness? Yes / No
Swollen joints? Yes / No
Joint pain? Yes / No
Osteoporosis Yes / No

Genitourinary:
Kidney stones? Yes / No
Blood in urine? Yes / No
Testicle pain? Yes / No
Menstrual problems? Yes / No

Neurologic:
Tingling/Numbness? Yes / No
Convulsions/Seizures? Yes / No
Frequent headache? Yes / No
Paralysis/Tremor? Yes / No
Loss of use of extremity Yes / No

Hematology:
Bruise easily? Yes / No
Slow to Heal? Yes / No
Enlarged glands? Yes / No

Skin:
Rash? Yes / No
Itching? Yes / No
Change in hair/nails? Yes / No

Gastrointestinal:
Nausea? Yes / No
Vomiting? Yes / No
Abdominal pain? Yes / No
Rectal bleeding? Yes / No
Bowel problems? Yes / No

Allergy/Immunology:
Food Allergy? Yes / No
Other? Yes / No
(if yes, let provider know)

Psychiatric:
Insomnia? Yes / No
Confusion/Memory loss? Yes / No
Depression? Yes / No

Breast:
Nipple discharge? Yes / No
Breast pain? Yes / No
Breast lump? Yes / No

Women's Health:
Number of pregnancies? _____
Number of deliveries? _____
Age of 1st pregnancy? _____
How many years have you used birth Control or Hormone Replacement Therapy? _____
Did you breast feed? Yes / No
Menses started at what age?_____
What age did Menopause Begin? _____
When was your last:
Screening Mammogram _____
Screening Pap Smear _____
Screening Pelvic Exam_____

Screening Dates:
When was your last:
Screening EKG _____
Screening Colonoscopy_____
Bone Density Scan _____
Last Eye Exam_____
By whom?_____

Vaccinations:
Date of last Pneumonia vaccine_____
Date of last Flu vaccine_____
Date of last TDAP / TD_____
Date of last Shingles vac_____

Advanced Directives:
Do you have Advanced Directives in place? Yes / No
Does your doctor have a copy? Yes / No

I have reviewed this packet & I Attest to its validity:

Please initial	Date

Mesa Family Physicians

For in-office use only
Chart #_____

Name:_____ **DOB:**_____ **Date:**_____

FUNCTIONAL QUESTIONNAIRE

Who do you live with :

- ☐ SPOUSE
- ☐ ALONE
- ☐ FAMILY
- ☐ INSTITUTION
- ☐ OTHER: _____

Exercise: (check those that apply)

Do you exercise regulary: Yes ____ No_____

Explain:_____

Do you require the following assistance: Yes ____ No _____

- ☐ CANE
- ☐ WALKER
- ☐ WHEELCHAIR
- ☐ SCOOTER

Do you require assistance while bathing or grooming: Yes _____ No_____

Do you require assistance preparing meals / eating: Yes _____ No_____

Are there any factors at home be them financial, social or others that negatively affect your health?

Yes _____ No _____ Explain _____

Date of last dental appointment:_____

History:

Previous history of tobacco use:	____Yes	____No
Burning, tingling, or numbness in extremities:	____Yes	____No
Pain or cramping in calf area during walking or exercise:	____Yes	____No
Previous foot ulcer or non-healing wound:	____Yes	____No
Pain in extremity that awakens from sleep:	____Yes	____No

(Below this line - For Office Use Only)

Timed Up & Go Test:

- ☐ More than 30 sec.
- ☐ Less than 30 sec.

Odd Gait: ____Yes ____No

Mesa Family Physicians

For in-office use only
Chart #_____

Name:_____ **DOB:**_____ **Date:**_____

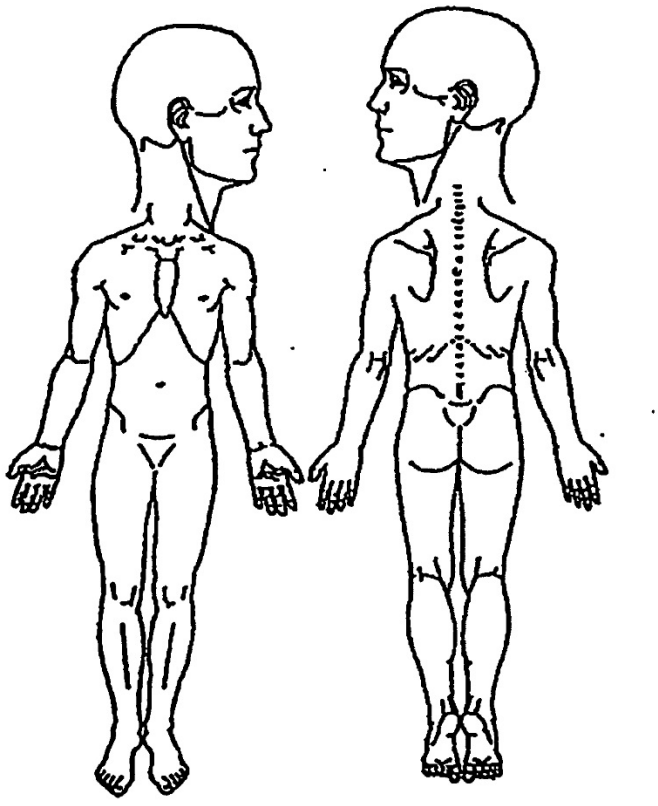
FALL RISK SCREENING

Please answer the following:

Y / N Have you had a fall in the last 3 months?
Y / N Do you suffer urinary or stool incontinence?
Y / N Do you have any visual impairment?
Y / N Is there anything in your environment that could result in your falling? (ie. stairs, loose rugs, etc.)
Y / N Do you use a device to help you balance when you walk?
Y / N Are you taking more than 3 medications or any medication that makes you confused or dizzy?
Y / N Do you suffer from pain that may increase your risk of falling?
Y / N Do you suffer from mental confusion or disorientation?

PAIN ASSESSMENT

Mark location of pain:



Y / N Do you have any chronic pain?
Where is it located? (Be specific on diagram)
How would you describe the pain?

____ throbbing
____ stabbing
____ cramping
____ hot-burning
____ heavy
____ splitting
____ shooting
____ sharp
____ gnawing
____ aching
____ tender

On a scale of 1-10, how would you rate each area of pain?

Pain Screening	0 1 2 3 4 5 6 7 8 9 10

Mesa Family Physicians

Chart #_____

Name:_____ **DOB:**_____ **Date:**_____

Neuropathy & Vascular Disease Screening

Examination:

Infection:	Yes / No
Ulceration:	Yes / No
Calluses or corns:	Yes / No
Skin Breaks:	Yes / No
Nail Disorder:	Yes / No
Foot deformity:	Yes / No
Foot temperature decreased:	Yes / No
Foot skin thinning:	Yes / No
Lack of foot hair:	Yes / No

Test for Neuropathy:

	Left Foot		**Right Foot**	
Monofilament	Normal	Abnormal	Normal	Abnormal
Vibration	Normal	Abnormal	Normal	Abnormal

Check Foot Pulses:

	Left Foot			**Right Foot**		
Dorsalis Pedis	Strong	Weak	Absent	Strong	Weak	Absent
Posterior Tibial	Strong	Weak	Absent	Strong	Weak	Absent

Venous Filling Time: Less than 20 seconds _____
More than 20 seconds _____

Mesa Family Physicians

For in-office use only
Chart #_____

PATIENT HEALTH QUESTIONNAIRE

Name:_____ **DOB:**_____ **Date:**_____

Over the last 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				
2) Feeling down, depressed, or hopeless				
3) Trouble falling or staying asleep, or sleeping too much				
4) 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				
7) Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9) Thoughts that you would be better off dead or of hurting yourself in some way				

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? (circle one)

Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult

Mesa Family Physicians

For in-office use only
Chart #_____

Name:_____ **DOB:**_____ **Date:**_____

S.A.F.E.-C

Self-Administered Functional Exam - Cognitive

1) What does the phrase, “People in glass houses shouldn’t throw stones” mean?
   a) Don’t be mean to others.
   b) Throwing stones in a glass house can break the glass and ruin the house.
   c) Don’t be hypocritical.
   d) People shouldn’t live in a glass house.

2) Count back by sevens from 100 and record the numbers.

3) Record the date, the season, the County and State.

4) What is the name of this object: 

5) Copy the following figure: