Patient History Form

DATE_____/_____/_____

Patient Name_____ Age _____ Date of Birth _____/_____/_____ MRN #_____

As part of your Medicare **Annual Wellness Visit,** please complete the following questionnaire to the best of your ability. It is an important and confidential part of your medical record.

Please list all of your Medical Providers and Suppliers involved in your care:

Please List All Current Medications and Supplements (include over-the-counter & prescription medicine)**:**

Please list any hospitalizations or surgeries you have undergone and the year performed:

Hospitalization / Surgery	**Year**

Do you smoke cigarettes?
☐ No ☐ Yes; how many packs per day? ___

Do you drink alcohol?
☐ No ☐ Yes; how many drinks per day? ___

Have you used drugs for recreation?
☐ No ☐ Yes; what type and when?
_____
_____

Have you or others in your immediate family (parents, grandparents, brothers, sisters, children or grandchildren) had any of the following? (Please check all that apply.)

	Self	**Family Member** (list relation)		**Self**	**Family Member** (list relation)		**Self**	**Family Member** (list relation)
General:			**Respiratory:**			**Neurologic:**		
Cancer: Breast	☐	☐	Asthma	☐	☐	Nerve Impairment	☐	☐
Cancer: Colon	☐	☐	Lung disease	☐	☐	Seizure disorder	☐	☐
Cancer: _____	☐	☐	Tuberculosis	☐	☐	Stroke	☐	☐
Weight loss/gain	☐	☐	Pneumonia	☐	☐		☐	☐
	☐	☐	Pleurisy	☐	☐	**Psychiatric:**		
Head:				☐	☐	Alcoholism	☐	☐
Trauma	☐	☐	**Gastrointestinal:**			Anxiety	☐	☐
Concussion	☐	☐	Colitis	☐	☐	Depression	☐	☐
	☐	☐	Diverticulitis	☐	☐	Mental illness	☐	☐
Eyes:			GERD	☐	☐	Phobias	☐	☐
Glaucoma	☐	☐	GI Bleed	☐	☐		☐	☐
Macular degeneration	☐	☐	Liver disease	☐	☐	**Endocrine:**		
	☐	☐	Stomach Ulcer	☐	☐	Diabetes	☐	☐
Ears, Nose, Mouth & Throat				☐	☐	Thyroid disease	☐	☐
Hearing loss	☐	☐	**Genitourinary:**				☐	☐
Vertigo	☐	☐	Enlarged Prostate	☐	☐	**Hematologic:**		
	☐	☐	Kidney Disease	☐	☐	Anemia	☐	☐
Cardiovascular:			Urinary Infection	☐	☐	Blood disorder	☐	☐
Congestive Heart Failure	☐	☐		☐	☐	**Immunologic:**		
Coronary Artery Disease	☐	☐	**Musculoskeletal:**			HIV	☐	☐
Heart disease	☐	☐	Arthritis	☐	☐	**Please list any other condition below:**		
High cholesterol	☐	☐	Fracture	☐	☐		☐	☐
Hypertension	☐	☐	Osteoporosis	☐	☐		☐	☐
Heart murmur	☐	☐					☐	☐
Heart arrhythmia	☐	☐	**Skin:**	☐	☐		☐	☐
Vascular disease	☐	☐	Eczema	☐	☐		☐	☐
	☐	☐	Psoriasis	☐	☐		☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Patient Signature: _____ Provider Signature: _____

Carolinas HealthCare System

Functional Abilities / Depression Questionnaire

Instructions: Patient and/or Patient's Representative complete Section A
Healthcare Team Member complete Section B

Patient name: _____ **Date:** _____

Section A

Functional Abilities Assessment: Please indicate Yes or No if you require assistance with any of the following activities.

Yes	No		Yes	No	
		Eating			Shopping
		Bathing			Climbing stairs
		Dressing			Communicating with others
		Grooming			Moving in and out of bed or chairs
		Going to the toilet			Following a prescribed drug regimen
		Preparing meals			Driving or accessing transportation services
		Housework			Managing finances

Please indicate Yes or No for each of the following questions about home safety.

Yes	No	
		Do you have any hearing difficulty or require hearing aid(s)?
		Are lamp, extension, and telephone cords placed out of the traffic flow?
		Are cords in good condition, out from under rugs and furniture?
		Do extension cords always carry their proper load?
		Are all small rugs and runners slip resistant?
		Are emergency numbers posted on or near telephones?
		Could you access a telephone should you experience a fall that prevents you from standing?
		Are all smoke detectors properly placed and in good working order?
		Are all small stoves and heaters placed where they cannot be knocked over and away from furnishings (furniture, curtains, rugs, etc.)?
		Is wood burning equipment installed properly?
		Do you have an emergency exit plan and alternate exit plan in case of fire?
		Are towels, curtains, and other things that might catch fire located away from the range?
		Are all extension cords and appliance cords located away from the sink or range areas?
		Are hallways, passageways between rooms and other heavy traffic areas well lit?
		Are exits and passageways kept clear?
		Are bathtubs and showers equipped with non-skid mats, abrasive strips, or surfaces that are not slippery?
		Do bathtubs and showers have at least one (preferably two) grab bars?
		Are all medicines stored in the containers that they came in and are they clearly marked?
		Is a lamp or light switch within reach of your bed?
		Are ash trays, smoking materials, or other fire sources (heaters, hot plates, teapots, etc.) located away from beds or bedding?
		Are heating pads always turned off before going to sleep?
		Is there a telephone close to your bed?
		Are stairs well lighted?
		Do the stair steps allow for secure footing?

Section B

Depression Assessment: Use PHQ-9 to evaluate the patient's risk for depression.

PHQ-9 is available on Canopy as a Power Form. Follow the link below for instructions on accessing this form.
https://carolinashealthcare.sharepoint.com/sites/eLink/preventive/Canopy%20Instructions%20for%20PHQ-9%200816.pdf

Non-Canopy users may access PHQ-9 via the following hyperlink.
https://carolinashealthcare.sharepoint.com/sites/eLink/preventive/Patient%20Depression%20Questionnaire%200816.pdf