Date______________________

Name______________________ Age__________ Single Married Divorced Widow(er)

Occupation______________________

Birth Place______________________ Birthdate______________________

Education______________ Years Highschool__________ Years College__________

FAMILY HISTORY

	Age	If Living Health	If Deceased Age at Death	Cause
Father				
Mother				
Brothers or Sisters				
Husband or Wife				
Sons or Daughters				

Has any blood relative ever had	No or Yes	Please Circle Who
Cancer		No or Yes
Tuberculosis		No or Yes
Diabetes	No or Yes	
Heart Trouble		No or Yes
High Blood Pressure		No or Yes
Stroke		No or Yes
Epilepsy	No or Yes	
Insanity		No or Yes

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

PERSONAL HISTORY: Please check ALL that applies		
ILLNESSES: Have you ever had	Have you ever been advised to have any	***NEUROLOGIC: Have you ever***
Measles	surgical operation which has not	Fainted or been knocked out
German Measles	been done No or Yes	Had numbness or tingling of arms,
Mumps	Have you been hospitalized for	legs or one side of body
Chicken Pox	any illness No or Yes	Had seizures or convulsions
Whooping Cough	Give Details:	Had a tremor
Scarlet Fever or Scarlentina		Been depressed
Diphtheria		Been treated for mental illness
Smallpox		Had unusual mood swings
Rheumatic fever or heart disease		Had a stroke
Polio or Meningitis		Had a warning of stroke or TIA
Gonorrhea or Syphilis	***GENERAL: Do you:***	***HEAD:***
Tuberculosis	Smoke ______ Packs per day ____.	Do you have headaches
ALLERGIES: Are you allergic to	Pipe ________Years___________.	Have you ever been injured
Penicillin or Sulfa	Cigars _______Quit ___________.	in the head No or Yes
Aspirin, Codeine or Morphine	Use Alcohol	***EYES: Do you***
Mycins or other Antibiotics	How much ________________.	Wear glasses or contacts
Merthiolate or Mercurochrome	Exercise regularly	Have pain in the eyes
Any other drug	Feel tired or run down	Blurry vision
Any foods	Have problems sleeping	Double vision
Adhesive tape	Have you ever had a	Have glaucoma
nail polish or other cosmetics	Blood transfusion	Have cataracts
Tetanus Antitoxin or Serums	***SKIN:***	Have flashing lights in front
SURGERY: Have you had	Any skin problems	of eyes or black
Tonsillectomy	Itching or burning	Have momentary or temporary
Appendectomy	Rash	blindness
Any other operation	Eczema or Hives	Have eye pain
Type Date	Varicose veins	Name of eye doctor
Type Date	Change in hair	
Type Date	Problems with toe or fingernails	Date last checked

EARS: Do you have

Pain in ears
Ringing, roaring or tinnitus
Discharge
Infections
Hearing problems
Balance problems

NOSE: Do you have

Sinus problems
Nose Bleeds
Loss of smell

MOUTH: Do you have

Dentures
Sores in mouth
Name of Dentist

NECK: Do yu have

Unusual lumps or bumps
Arthritis
Goiter or thyroid problems

Blood: Do you

Bruise easily
Have bleeding problems
Have anemia or low blood
Any blood diseases

RESPIRATORY: Have you ever

Had bronchitis or pneumonia
Had weezing, asthma, hay fever
Coughed up blood
Been told you hav emphysema
Worked around:
  Asbestos
  Silica dust and sand
  Coal dust
  Toxic chemicals
Had a chest x-ray
  When
Had pleurisy
Had night sweats
Have a chronic cough
Cough up phlegm
Do you get shor of breath
  When

CARDIAC: Do you have

High blood pressure
Any heart problems
A heart murmur
Chest pain, tightness, discomfort
Palpitations or skip beats
Swelling of hands or feet
Do you wake up at night short
  of breath
Use more than 1 pillow
Get out of breath going uphill
  Up stairs
  On level ground
Do you have angina
Have you ever been told you had
  a heart attack
Do you get leg cramps

GASTRONINTESTINAL:

Appetite Good Poor
Do you have aor have ever had
  a change in weight
Trouble swallowing
Heartburn or indigestion
Ulcers
Hepatitis or yellow jaundice
Problems with nausea and
  vomiting
Problems with fried food or
  fatty food
Gallbladder problems
Any problems with bowel movement

How often do bowels move
Use laxatives
Bleeding in bowels
Vomiting blood
Hemorrhoids
Problems with diarrhea

GENITOURINARY: Have you ever had

Bladder or kidney infections
Passed blood
Passed a stone
Lose control of urine with cough,
  sneeze, exercise
Do you get up at night to urinate
How often

ENDOCRINE: Do you have

Excess thirst or urination
Inability to withstand hear or
  cold
Change in texture of hair
Dry skin
Any diabetes in family
Any thyroid problems or goiter in
  family

MUSCULOSKELETAL:

Any broken bones
which bones

Arthritis
Which joints

Do your joints get red, hot, swollen
Any back pain or problems

MEN ONLY: Do you have

Prostate problems
Weak or slow urine
Burning or discharge from penis
Swelling or lumps in testicles
Hernia or rupture
Difficulty getting or maintaining
  an erection

WOMEN ONLY:

Age when periods started
Age when periods stopped
Date of last period
Date of last pap smear
Periods Regular Irregular
  Usually painful Heavy
Any vaginal bleeding between
  periods
Vaginal discharge
Pain in pelvis
Do you now use or did you ever use
  IUD
  Birth control pills
Pregnancies:
How many
How many stillbirths
How many premature
How many miscarriges
Any complications
Do you have
  Brest lumps
  Breast pain
  Breast discharge
Any relative with breast cancer

COMMENTS:

The Patient Health Questionnaire (PHQ-9)

Patient Name ______________________ Date of Visit ____________

Over the past 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	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, 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're 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

Column Totals ______ + ______ + ______

Add Totals Together ______________

10. If you checked off any problems, how difficult have those 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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CAGE-AID Questionnaire

Patient Name ______________________________ Date of Visit ____________

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

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Tennessee Department of Health
Division of Health Licensure and Regulation
Office of Health Care Facilities
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www.tn.gov/health

ADVANCE CARE PLAN
(Tennessee)

I, ______________________________, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: ______________________________ Phone #: (___)____________ Relation: ______________________
Address: ____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: ______________________________ Phone #: (___)____________ Relation: ______________________
Address: ____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one):

☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.
☐ I do not give such permission (this form applies only when I no longer have capacity).

Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an unacceptable quality of life).

☐ Yes ☐ No	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	Permanent Confusion: I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I do not want.

☐ Yes ☐ No	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	Life Support / Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☐ No	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	Tube feeding/IV fluids: Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Please sign on page 2

Other instructions, such as burial arrangements, hospice care, etc.: ______________________________

____

____

____

(Attach additional pages if necessary)

Organ donation: Upon my death, I wish to make the following anatomical gift (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: ______________

____

☐ No organ/tissue donation

SIGNATURE

Your signature must either be witnessed by two competent adults or notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Signature: ______________________________ (Patient) DATE: ______________________________

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE

County of ______________________________

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

Notary Public: ______________________________
Signature

My commission expires: ______________________________

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent