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	Chest pain, tightness, discomfort	Dry skin
Pain in ears	Palpitations or skip beats	Any diabetes in family
Ringing, roaring or tinnitus	Swelling of hands or feet	Any thyroid problems or goiter in
Discharge	Do you wake up at night short	family
Infections	of breath	***MUSCULOSKELETAL:***
Hearing problems	Use more than 1 pillow	Any broken bones
Balance problems	Get out of breath going uphill	which bones
NOSE: Do you have	Up stairs	
Sinus problems	On level ground	Arthritis
Nose Bleeds	Do you have angina	Which joints
Loss of smell	Have you ever been told you had	
MOUTH: Do you have	a heart attack	Do your joints get red, hot, swollen
Dentures	Do you get leg cramps	Any back pain or problems
Sores in mouth	***GASTRONINTESTINAL:***	***MEN ONLY: Do you have***
Name of Dentist	Appetite Good Poor	Prostate problems
	Do you have aor have ever had	Weak or slow urine
NECK: Do yu have	a change in weight	Burning or discharge from penis
Unusual lumps or bumps	Trouble swallowing	Swelling or lumps in testicles
Arthritis	Heartburn or indigestion	Hernia or rupture
Goiter or thyroid problems	Ulcers	Difficulty getting or maintaining
Blood: Do you	Hepatitis or yellow jaundice	an erection
Bruise easily	Problems with nausea and	***WOMEN ONLY:***
Have bleeding problems	vomiting	Age when periods started
Have anemia or low blood	Problems with fried food or	Age when periods stopped
Any blood diseases	fatty food	Date of last period
RESPIRATORY: Have you ever	Gallbladder problems	Date of last pap smear
Had bronchitis or pneumonia	Any problems with bowel movement	Periods Regular Irregular
Had weezing, asthma, hay fever		Usually painful Heavy
Coughed up blood	How often do bowels move	Any vaginal bleeding between
Been told you hav emphysema	Use laxatives	periods
Worked around:	Bleeding in bowels	Vaginal discharge
Asbestos	Vomiting blood	Pain in pelvis
Silica dust and sand	Hemorrhoids	Do you now use or did you ever use
Coal dust	Problems with diarrhea	IUD
Toxic chemicals	***GENITOURINARY: Have you ever had***	Birth control pills
Had a chest x-ray	Bladder or kidney infections	Pregnancies:
When	Passed blood	How many
Had pleurisy	Passed a stone	How many stillbirths
Had night sweats	Lose control of urine with cough,	How many premature
Have a chronic cough	sneeze, exercise	How many miscarriges
Cough up phlegm	Do you get up at night to urinate	Any complications
Do you get shor of breath	How often	Do you have
When	***ENDOCRINE: Do you have***	Brest lumps
CARDIAC: Do you have	Excess thirst or urination	Breast pain
High blood pressure	Inability to withstand hear or	Breast discharge
Any heart problems	cold	Any relative with breast cancer
A heart murmur	Change in texture of hair	

COMMENTS:

Mountain Region Family Medicine
444 Clinchfield Street, Suite 201
Kingsport, TN 37660

MEDICARE WELLNESS CHECKUP

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

Your name: _____

_____

Today's date: _____

Your date of birth: _____

1. What is your age?

☐ 65-69. ☐ 70-79. ☐ 80 or older.

2. Are you a female or a male?

☐ Male. ☐ Female.

3. During the **past four weeks,** how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

4. During the **past four weeks,** has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

5. During the **past four weeks,** how much bodily pain have you generally had?

☐ No pain.
☐ Very mild pain.
☐ Mild pain.
☐ Moderate pain.
☐ Severe pain.

6. During the **past four weeks,** was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

☐ Yes, as much as I wanted.
☐ Yes, quite a bit.
☐ Yes, some.
☐ Yes, a little.
☐ No, not at all.

7. During the **past four weeks,** what was the hardest physical activity you could do for at least two minutes?

☐ Very heavy.
☐ Heavy.
☐ Moderate.
☐ Light.
☐ Very light.

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)

☐ Yes. ☐ No.

9. Can you go shopping for groceries or clothes without someone's help?

☐ Yes. ☐ No.

10. Can you prepare your own meals?

☐ Yes. ☐ No.

11. Can you do your housework without help?

☐ Yes. ☐ No.

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

☐ Yes. ☐ No.

13. Can you handle your own money without help?

☐ Yes. ☐ No.

14. During the **past four weeks,** how would you rate your health in general?

☐ Excellent.
☐ Very good.
☐ Good.
☐ Fair.
☐ Poor.

continued ➤

15. How have things been going for you during the **past four weeks**?

- ☐ Very well; could hardly be better.
- ☐ Pretty well.
- ☐ Good and bad parts about equal.
- ☐ Pretty bad.
- ☐ Very bad; could hardly be worse.

16. Are you having difficulties driving your car?

- ☐ Yes, often.
- ☐ Sometimes.
- ☐ No.
- ☐ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	☐	☐	☐	☐	☐
Sexual problems.	☐	☐	☐	☐	☐
Trouble eating well.	☐	☐	☐	☐	☐
Teeth or denture problems.	☐	☐	☐	☐	☐
Problems using the telephone.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

19. Have you fallen two or more times in **the past year**?

☐ Yes. ☐ No.

20. Are you afraid of falling?

☐ Yes. ☐ No.

21. Are you a smoker?

- ☐ No.
- ☐ Yes, and I might quit.
- ☐ Yes, but I'm not ready to quit.

22. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- ☐ 10 or more drinks per week.
- ☐ 6-9 drinks per week.
- ☐ 2-5 drinks per week.
- ☐ One drink or less per week.
- ☐ No alcohol at all.

23. Do you exercise for about 20 minutes three or more days a week?

- ☐ Yes, most of the time.
- ☐ Yes, some of the time.
- ☐ No, I usually do not exercise this much.

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes. ☐ No.

Keeping track of your medications?

☐ Yes. ☐ No.

25. How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine.
- ☐ I always take them as prescribed.
- ☐ Sometimes I take them as prescribed.
- ☐ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident.
- ☐ Somewhat confident.
- ☐ Not very confident.
- ☐ I do not have any health problems.

27. What is your race? (**Check all that apply.**)

- ☐ White.
- ☐ Black or African American.
- ☐ Asian.
- ☐ Native Hawaiian or Other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Family Practice Management

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

Fall Prevention Balance and Dizziness Survey

Patient Name: _____ **Age:** _____ **Date:** _____

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

Please read each question and check the box that most describes your answer.	Yes or Often	Some-times	No or Never
1. Do you ever lose your balance or feel dizzy or unsteady?			
2. Have you continued to experience dizziness after an injury or accident?			
3. Do you feel unsteady when you are walking or climbing stairs?			
4. Do you feel dizzy while sitting down or rising from a seated or lying position?			
5. Does walking down the isle of a supermarket or stopping next to moving traffic make you dizzy?			
6. Does moving your head quickly make you dizzy or cause you to feel nauseous?			
7. Are you dizzy or unsteady when you first get up in the morning?			
8. Do you ever fall or feel like you are about to fall for no apparent reason?			
9. Do you use a walker, cane, or any other form of assistance for your mobility?			
10. Have you had a recent loss of, or decrease in, your vision or hearing?			
11. Do you fear falling?			
12. Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			
13. Has your balance problem caused problems in your social life?			
14. Have you fallen more than once in the past year without an obvious cause?			
15. Does dizziness or imbalance interfere with your job or your household responsibilities?			

Please fill out the top with your name and date, sign the survey at the bottom and provide this to your physician during your visit.

_____ _____

Patient Signature Phone

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?	☐	☐

Permission for use granted by Richard Brown, MD.

Instrumental Activities of Daily Living (IADL)

Instructions: Circle the scoring point for the statement that most closely corresponds to the patient's current functional ability for each task. The examiner should complete the scale based on information about the patient from the patient him-/herself, informants (such as the patient's family member or other caregiver), and recent records.

A. Ability to use telephone	Score
1. Operates telephone on own initiative; looks up and dials numbers, etc.	1
2. Dials a few well-known numbers	1
3. Answers telephone but does not dial	1
4. Does not use telephone at all	0

B. Shopping	
1. Takes care of all shopping needs independently	1
2. Shops independently for small purchases	0
3. Needs to be accompanied on any shopping trip	0
4. Completely unable to shop	0

C. Food preparation	
1. Plans, prepares, and serves adequate meals independently	1
2. Prepares adequate meals if supplied with ingredients	0
3. Heats and serves prepared meals, or prepares meals but does not maintain adequate diet	0
4. Needs to have meals prepared and served	0

D. Housekeeping	
1. Maintains house alone or with occasional assistance (e.g., "heavy work domestic help")	1
2. Performs light daily tasks such as dishwashing, bed making	1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	1
4. Needs help with all home maintenance tasks	1
5. Does not participate in any housekeeping tasks	0

E. Laundry	Score
1. Does personal laundry completely	1
2. Launders small items; rinses stockings, etc.	1
3. All laundry must be done by others	0

F. Mode of transportation	
1. Travels independently on public transportation or drives own car	1
2. Arranges own travel via taxi, but does not otherwise use public transportation	1
3. Travels on public transportation when assisted or accompanied by another	1
4. Travel limited to taxi or automobile with assistance of another	0
5. Does not travel at all	0

G. Responsibility for own medications	
1. Is responsible for taking medication in correct dosages at correct time	1
2. Takes responsibility if medication is prepared in advance in separate dosages	0
3. Is not capable of dispensing own medication	0

H. Ability to handle finances	
1. Manages financial matters independently (budgets, writes checks, pays rent and bills, goes to bank), collects and keeps track of income	1
2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
3. Incapable of handling money	0

(Lawton & Brody, 1969)

Tennessee Department of Health
Division of Health Licensure and Regulation
Office of Health Care Facilities
665 Mainstream Drive, Second Floor
Nashville, TN 37243
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: _____ DATE: _____
(Patient)

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