Scituate Family Practice

Name: ______________________________________ Date: ______________________________

Since your last exam, have you had:

Any new health issues:
____

Recent hospitalizations or surgery:
____

Changes in your family medical history:
____

Changes in social situation:
____

Please indicate if you have had any of the following symptoms:

__ Fatigue __ Weight gain or loss __ Swelling

__ Chest pain __ Headaches __ Abdominal pain

__ Shortness of breath __ Decreased hearing __ Change in bowels

__ Cough __ Vision concerns __ Urinary problems

__ Joint pains __ Anxiety __ Sexual concerns

Do you drink alcohol? ___ Yes ___ No

How much? ____

Do you smoke tobacco? ___ Yes ___ No

How much? ____

Do you exercise? ___ Yes ___ No

How much? ____

Please indicate if you have concerns in any of the following areas:

___ Housing ___ Transportation

___ Food ___ Language Barriers

___ Finances ___ Social anxiety/isolation

Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than one-half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Are you interested in discussing a health care proxy and/or advanced directives at today's visit?

___ Yes ___ No