Exton Family Medicine

Bryn Mawr Medical Specialists Association

INITIAL/ANNUAL VISIT EVALUATION

Please answer all questions to help us maintain accurate records. All information will be kept confidential.

Patient Name:________________________________ DOB:_____________ Date:______________

ALL MEDICATIONS(with dose) include over the counter and supplements ○ **NONE**

1	6
2	7
3	8
4	9
5	10

ALLERGIES to Medication(s) ○ No ○ YES if yes, please list

Medication:	**Reaction:**

CHRONIC CONDITIONS/PAST MEDICAL HISTORY please check

high blood pressure	○	anxiety	○	allergies	○
high cholesterol	○	stroke	○	migraines	○
diabetes	○	thyroid problems	○	anemia	○
heart attack	○	liver problems	○	arthritis	○
heart failure	○	kidney problems	○	drug/alcohol problems	○
depression	○	asthma	○	**NONE**	○

Cancer ○ type:________________________________

Others:____

HOSPITALIZATIONS(Reasons) and DATES (approximate)

1____ **3** ______________________________________

2____ **4**______________________________________

PREVIOUS SURGERIES/PROCEDURES and DATES

1____ **3**______________________________________

2____ **4**______________________________________

SPECIALISTS YOU SEE and WHY

1____ **3**______________________________________

2____ **4**______________________________________

PLEASE COMPLETE OTHER SIDE>

FAMILY HISTORY Has anyone in your IMMEDIATE family had:

ILLNESS	MEMBER	ILLNESS	MEMBER
high blood pressure		stroke	
high cholesterol		asthma	
diabetes		osteoporosis	
heart attack		kidney disease	
depression		genetic disorders	
bipolar		cancer(type)	
suicide		other:	

Is your mother alive? ○ YES ○ NO if not, age and cause of death____

Is your father alive? ○ YES ○ NO if not, age and cause of death____

Any siblings? ○ NO ○ Yes if yes, how many? Brothers:_____ Sisters:_____ Alive/deceased___________________

How many children? _____

SOCIAL/OCCUPATIONAL HISTORY

Do you use tobacco products? ○ No ○ Yes what kind?___________ how much/day?______ years used?____

Do you drink alcohol? ○ No ○ Yes what kind?______________ how much/day?_______________

Do you drink caffeine? ○ No ○ Yes what kind?______________ how much/day?_______________

Do you exercise? ○ No ○ Yes what type?______________ how much/week?_______________

Do you follow a particular diet? ○ No ○ Yes what type?___________________________________

Do you have smoke detectors? ○ No ○ Yes

Do you wear a seatbelt? ○ No ○ Yes **Do you use sunscreen?** ○ No ○ Yes

Have you recently traveled outside the U.S.? ○ No ○ Yes if yes, where?_________________

Do you have a living will or advance directive? ○ No ○ Yes

****The following answers are confidential****

Do you use illegal drugs? ○ No ○ Yes

Are you sexually active? ○ No ○ Yes

Do you use contraception? ○ No ○ Yes if yes, what kind?________________

Occupation:____

HEALTH MAINTENANCE

When was your LAST(approximate)?

Complete Physical:_____________

Colonoscopy:_________________

Blood Tests:__________________

Females only PAP Smear__________

GYN exam__________

Mammogram__________

Dexa Scan_________

Males only PSA__________

IMMUNIZATIONS

Flu ○ No ○ Yes date:_________

Tetanus/Tdap ○ No ○ Yes date:_______

Pneumonia/Prevnar ○ No ○ Yes date:_______

Meningococcal ○ No ○ Yes date:_______

Hepatitis B ○ No ○ Yes date:_______

HPV ○ No ○ Yes date:_______

Zoster/Shingles ○ No ○ Yes date:_______

PATIENT HEALTH QUESTIONNAIRE (PHQ-2): Please circle your response.

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	several days	more than a week	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**