Bryn Mawr Medical Specialists Association

Patient Label

# Patient Intake Form

Patient DOB:
Account #:

## Patient Information

Today's Date: _____ Last Name: _____ First Name: _____

## Medical History

**All Patients**

| Question | Yes | No | Last Date | Comment |
|---|---|---|---|---|
| 1. What is the date of your last appointment with your primary care provider (PCP)? | | | | Who is your PCP? _____ |
| 2. Have you had a flu shot between August 1, 2019 to March 31, 2020? | | | | If not, why not? |
| 3. Are you a current tobacco user? (any type) | | | | Describe use: |
| 4. Have you ever been diagnosed with colorectal cancer? | | | | |
| 5. Have you had surgery to remove all of the intestine (total colectomy)? | | | | |
| 6. Have you had a Colonoscopy within the last 10 years? | | | | Where was this performed?<br>Were your results normal? ❑ Yes ❑ No |
| 7. Have you had a Flexible Sigmoidoscopy within the last 5 years? | | | | Where was this performed?<br>Were your results normal? ❑ Yes ❑ No |
| 8. Have you had a Fecal Occult Stool Test in 2019? | | | | Where was this performed?<br>Were your results normal? ❑ Yes ❑ No |
| 9. Have you had a CT colonography within the last 5 years? | | | | Where was this performed?<br>Were your results normal? ❑ Yes ❑ No |
| 10. Have you had a stool FIT or stool DNA test within the last 3 years (e.g. Cologuard)? | | | | Where was this performed?<br>Were your results normal? ❑ Yes ❑ No |
| 11. Have you fallen in the past year? | | | | How many times did you fall? ____<br>Were you injured? ❑ Yes ❑ No |

**Female Patients Only**

| Question | Yes | No | Last Date | Comment |
|---|---|---|---|---|
| 12. Have you had a mastectomy?<br>Where was this performed? | | | | ❑ Left Breast (separate surgery) Date: _____<br>❑ Right Breast (separate surgery) Date: _____<br>❑ Both Breasts (same surgery) Date: _____ |
| 13. Have you had a mammogram since January 1, 2017? | | | | Where was this performed?<br>Were your results normal? ❑ Yes ❑ No |

**Diabetic Patients Only**

| Question | Yes | No | Last Date | Comment |
|---|---|---|---|---|
| 14. Have you had a diabetic eye exam in the last year by an eye care specialist? | | | | Where was this performed?<br>Were your results normal? ❑ Yes ❑ No |

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# Patient Intake Form

Patient Label

Patient DOB:
Account #:

## Patient Information

Today's Date: _____ Last Name: _____ First Name: _____

| All Patients - Depression Screening | | | |
|---|---|---|---|
| **Question** | **Response** | | **Comment** |
| 15. Are you currently being treated for depression or bipolar disorder? | ❑ Yes [Stop] | ❑ No [Continue] | If you answered "Yes", you are done with this form. If you answered "No", proceed to Question 16. |

| Question | Response | |
|---|---|---|
| 16. How many days in the last two (2) weeks did you have little interest in doing things? | ❑ 0 – None<br>❑ 1 – Several days | ❑ 2 – More than half the time<br>❑ 3 – Nearly every day |
| 17. How many days in the last two (2) weeks did you feel down, depressed or hopeless? | ❑ 0 – None<br>❑ 1 – Several days | ❑ 2 – More than half the time<br>❑ 3 – Nearly every day |

If you answered "0 – None" to Question 16 **and** "0 – None" to Question 17, you are done with this form otherwise answer questions 18 through 24.

**Depression Screening – Additional Questions**

| Question | 0 – None at all | 1 – Several days | 2 – More than half the days | 3 – Nearly every day |
|---|---|---|---|---|
| 18. How many days in the last two (2) weeks did you have trouble falling or staying asleep or sleeping too much? | | | | |
| 19. How many days in the last two (2) weeks did you feel tired or have little energy? | | | | |
| 20. How many days in the last two (2) weeks did you have poor appetite, weight loss or do you overeat? | | | | |
| 21. How many days in the last two (2) weeks did you feel bad about yourself or that you are a failure, or have let yourself or your family down? | | | | |
| 22. How many days in the last two (2) weeks did you have trouble concentrating on things, such as reading, watching television or schoolwork? | | | | |
| 23. How many days in in the last two (2) weeks did you move or speak so slowly that other people have noticed? Or, that you were fidgety or restless that you moved around a lot more than usual? | | | | |
| 24. How many days in the last two (2) weeks did you have thoughts that you would be better off dead or of hurting yourself in some way? | | | | |