Medical History Update, Adult

Patient Name: ____ **Date of Birth:** ______________

Today's Date: ______________

Date of your last physical visit at Dry Ridge Family Medicine: ______________

MEDICAL HISTORY UPDATE

Since your last physical, please list any new health problems or health concerns:

____

____

____

____

Since your last physical, please list any hospitalizations or surgeries you've had, and the approximate dates:

____

____

____

____

If another provider is prescribing you medication(s), or if you are taking over-the-counter medications, vitamins, or supplements we may not be aware of, please list them here:

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

Please list any new medication allergies, including the type of reaction:

____

____

____

____

Medical History Update, Adult

Patient Name: ____ Date of Birth: ______________

SOCIAL HiSTORY UPDATE

Marital Status: ____Single ____Married ____Divorced ____Separated

____Widowed ____Live w/Significant Other

How many people, including yourself, live in your household? ____________________

What is the relationship of the other people in your household (spouse, son, mother, cousin, friend, etc.)?

____

____

Employment Status

____Full-Time ____Part-Time ____Homemaker ____Retired ____Disabled ____Student ____Unemployed

If employed, employer and job title: ____

Do you feel safe in your home? ____Yes ____No

If not, please list concerns: ____

____

Do you currently use tobacco? ____Yes, and I might quit ____Yes, but I'm not ready to quit ____No

If yes, what kind: ____Cigarettes ____Chew ____Snuff ____Cigars

If you smoke, how many packs per day and for how many years? ________________________

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

____10 more drinks per week ____6-9 drinks per week ____2-5 drinks per week

____One drink or less per week ____No alcohol at all

Do you currently use any illegal drugs? (this information is kept confidential) ____Yes ____No

If yes, please list what kind and how often you use them (daily, weekly, monthly?):

____

Medical History Update, Adult

Dry Ridge
FAMILY MEDICINE PLLC

Patient Name: ____ Date of Birth: ______________

Are you currently following any special diet? ____Yes ____No

If yes, what kind: ____Vegan ____Vegetarian ____Low Cholesterol ____Gluten Free

____Diabetes Diet ____Other: ____

Do you currently exercise? ____Yes ____No

If yes, list what kind of exercise and how often: ____________________________________

____

Hobbies: ____

FAMILY HISTORY UPDATE:

Since your last physical, has your family history or living situation changed? ____Yes ____No

Mother Is she? ____Alive ____Deceased List current age, or the age she died: _______

New medical problems, if any: ____

____

Father Is he? ____Alive ____Deceased List current age, or the age he died: _______

New medical problems, if any: ____

____

Brothers How many? ____________________

List current ages if applicable: ____

New medical problems, if any: ____

____

Sisters How many? ____________________

List current ages if applicable: ____

New medical problems, if any: ____

____

PATIENT HEALTH QUESTIONNAIRE (PHQ-2/9)

Today's Date: _____________

Patient Name: _____________________________________ **Date of Birth:** _____________

Part of routine screening for your health includes reviewing mood and emotional concerns.
During the past two weeks, have you often been bothered by any of the following problems?

Little interest or pleasure in doing things? _____Yes _____No
Feeling down, depressed, irritable or hopeless? _____Yes _____No

If you answered "Yes" to either question above, please answer all questions below:

Over the last 2 weeks, how often have you been bothered by any of the following problems?	(0) **Not at all**	(1) **Several days**	(2) **More than half the days**	(3) **Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed, irritable, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite, weight loss, or overeating				
Feeling bad about yourself — feeling that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you are experiencing any of the problems above, how difficult have these 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

For Office Use Only **Total Score** ________

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Your Medical Providers

Primary Care Physician	Dry Ridge Family Medicine - Nicole Ogg, MD
Eye Doctor	____
Dentist	____
Chiropractor	____

Specialists

Cardiologist	____
Dermatologist	____
Endocrinologist	____
Gastroenterologist	____
Gynecologist	____
Infectious disease specialist	____
Internist	____
Neurologist	____
Orthopedist	____
Pain Management	____
Podiatrist	____
Rheumatologist	____
Urologist	____

Other Medical Providers

______________________	______________________________
______________________	______________________________
______________________	______________________________

Verbal Communication Release Form

Our patients often want us to verbally communicate with family or friends who are assisting them in their treatment or payment for treatment. Please list below any **family or friends** with whom you authorize us to discuss your treatment/care or billing information, either in person or by phone.
This authorization will remain in effect for a period of one year from the date signed unless you revoke it.

Patient Name: ____ **Date of Birth:** _________________

____Communicate with me only

____Communicate with me and/or the following people:

Name (printed): ___________________________________ Relationship to Patient ____________
Treatment/Care Information: ____Yes ____No
Billing Information: ____Yes ____No

Name (printed): ___________________________________ Relationship to Patient ____________
Treatment/Care Information: ____Yes ____No
Billing Information: ____Yes ____No

Name (printed): ___________________________________ Relationship to Patient ____________
Treatment/Care Information: ____Yes ____No
Billing Information: ____Yes ____No

Name (printed): ___________________________________ Relationship to Patient ____________
Treatment/Care Information: ____Yes ____No
Billing Information: ____Yes ____No

Emergency Contact
Someone we may contact in the event of an emergency and we need to reach someone on your behalf.
Please provide an emergency contact even if you checked 'Communicate with me only' above.

Emergency Contact Name (printed): ____
Relationship to Patient: _________________________________
Phone (two numbers if available): Home: _______________ Cell: _______________
Work: _______________ Other: _______________

______________________________________ ________________________________
Patient's Signature Today's Date

______________________________________ ________________________________
If applicable, Authorized Representative Date
Relationship to Patient ______________________________