Present Symptoms

Are you currently having any of the following symptoms?

General:

- [ ] fatigue
- [ ] body aches
- [ ] chills
- [ ] sweats
- [ ] night sweats
- [ ] decreased energy
- [ ] other concerns
- [ ] no current symptoms

Neurological:

- [ ] headache
- [ ] seizure
- [ ] loss of consciousness or fainting
- [ ] paralysis
- [ ] weakness
- [ ] muscle spasms
- [ ] tremors
- [ ] involuntary movement
- [ ] numbness
- [ ] feeling of pins and needles
- [ ] other concerns
- [ ] no current symptoms

Eye, Ear, Nose, and Throat:

- [ ] Blurred vision
- [ ] double vision
- [ ] eye pain
- [ ] flashing lights
- [ ] spots in the vision
- [ ] wears glasses
- [ ] wears contacts
- [ ] eye drainage
- [ ] eye itching
- [ ] eye redness
- [ ] foreign body sensation in the eye
- [ ] decreased vision
- [ ] ear pain
- [ ] ear fullness
- [ ] decreased hearing
- [ ] ear drainage
- [ ] sinus congestion
- [ ] sinus pain
- [ ] sinus pressure
- [ ] runny nose
- [ ] sneezing
- [ ] frequent bleeding from the nose
- [ ] facial pain
- [ ] sore throat
- [ ] tongue swelling
- [ ] hoarseness a voice
- [ ] bleeding gums
- [ ] painful guns
- [ ] swollen glands in the neck
- [ ] lump in throat
- [ ] other concerns
- [ ] no current symptoms

Cardiac:

- [ ] Chest pain
- [ ] palpitations
- [ ] swelling in the hands or feet
- [ ] legs swelling
- [ ] blue fingers or toes
- [ ] high blood pressure
- [ ] sensation of heart skipping a beat
- [ ] known history of heart murmur
- [ ] shortness of breath when lying flat
- [ ] other concerns
- [ ] no current symptoms

Respiratory:

- [ ] Shortness of breath
- [ ] cough
- [ ] chest congestion
- [ ] coughing up sputum
- [ ] wheezing
- [ ] coughing up blood
- [ ] snoring
- [ ] waking up short of breath
- [ ] early morning headache
- [ ] other concerns
- [ ] no current symptoms

Abdominal:

- [ ] Increased appetite
- [ ] decreased appetite
- [ ] weight gain
- [ ] weight loss
- [ ] problems swallowing
- [ ] nausea
- [ ] heartburn
- [ ] vomiting
- [ ] constipation
- [ ] diarrhea
- [ ] change in bowel habits
- [ ] abdominal pain
- [ ] excessive belching
- [ ] excessive flatus
- [ ] food intolerance
- [ ] rectal bleeding
- [ ] hemorrhoids
- [ ] other concerns
- [ ] no current symptoms

When was your last bowel movement?

- [ ] Today
- [ ] Yesterday
- [ ] 2 days ago
- [ ] 3 days ago
- [ ] 4 days ago
- [ ] 5 days ago

Genitourinary:

- [ ] Difficulty urinating
- [ ] burning with urination
- [ ] pain with urination
- [ ] frequently urinating at night
- [ ] urgent need to urinate
- [ ] incontinence of urine
- [ ] dribbling
- [ ] frequency of urination
- [ ] decreased urine stream
- [ ] blood in the urine
- [ ] frequent urinary infections
- [ ] other concerns
- [ ] no current symptoms

Skin:

- [ ] Rash
- [ ] itching
- [ ] change and hair or nails
- [ ] open wound
- [ ] other concerns
- [ ] no current symptoms

Musculoskeletal:

- [ ] Neck pain
- [ ] upper back pain
- [ ] mid back pain
- [ ] low back pain
- [ ] hand pain
- [ ] forearm pain
- [ ] elbow pain
- [ ] upper arm pain
- [ ] shoulder pain
- [ ] hip pain
- [ ] thigh pain
- [ ] knee pain,
- [ ] lower leg pain
- [ ] ankle pain
- [ ] foot pain
- [ ] swelling
- [ ] stiffness
- [ ] decrease in joint motion
- [ ] arthritis
- [ ] gout
- [ ] other concerns
- [ ] no current symptoms

Endocrine:

- [ ] Increase appetite
- [ ] increased thirst
- [ ] increase urine production
- [ ] heat intolerance
- [ ] cold intolerance
- [ ] excessive sweating
- [ ] other concerns
- [ ] no current symptoms

Psychiatric:

- [ ] Tension
- [ ] anxiety
- [ ] depression
- [ ] decreased short-term memory
- [ ] loss of long-term memory
- [ ] difficulty falling asleep
- [ ] difficulty staying asleep
- [ ] nightmares
- [ ] decreased energy
- [ ] decreased concentration
- [ ] decreased self-esteem
- [ ] guilt
- [ ] hopelessness
- [ ] loss of interest in activities she wants enjoyed
- [ ] mood swings
- [ ] irritability
- [ ] restlessness
- [ ] social isolation
- [ ] moving or speaking so slowly that others have noticed
- [ ] none of the above

Females:

- [ ] breast lump
- [ ] nipple discharge
- [ ] breast pain
- [ ] other breast concerns
- [ ] heavy menstrual bleeding
- [ ] irregular vaginal bleeding
- [ ] other menstrual concerns
- [ ] vaginal discharge
- [ ] vaginal itching
- [ ] vaginal odor
- [ ] pelvic pain
- [ ] concerns for sexually transmitted infection
- [ ] other concerns
- [ ] no current symptoms

When was your last menstrual period?

Males:

- [ ] pain in penis
- [ ] pain in testicles
- [ ] pain in scrotum
- [ ] testicular mass
- [ ] Scrotal mass
- [ ] premature ejaculation
- [ ] inability to obtain erection
- [ ] inability to maintain erection
- [ ] discharge from penis
- [ ] concerns for sexually transmitted infection
- [ ] other concerns
- [ ] no current symptoms

If you are not having symptoms, you may select the following option:

- [ ] I am not currently having any symptoms.

Symptom Details

Please tell me more about your symptoms. You can leave it blank if the question does not apply.

How long have your symptoms been present?

Are your symptoms present all day or do they come and go?

How would you describe your symptoms?

How severe would you say your symptoms are?

Have you tried anything to treat your symptoms and did it help?

Does anything make your symptoms worse?

How long do your symptoms last when they happen?

General Health History

If a question does not apply, you may leave it blank.

Have you been diagnosed with any of the following health conditions?

- [ ] Allergic Rhinitis
- [ ] Anemia
- [ ] Anxiety
- [ ] Arthritis
- [ ] Asthma
- [ ] Benign Prostate Enlargement
- [ ] Bipolar disorder
- [ ] Cancer
- [ ] Cerebrovascular disease
- [ ] Chronic Bronchitis
- [ ] Chronic Kidney Disease
- [ ] Chronic Obstructive Pulmonary Disease (COPD)/Emphysema
- [ ] Chronic pancreatitis
- [ ] Congestive heart failure (CHF)
- [ ] Crohn's Disease
- [ ] Deep Vein Thrombosis
- [ ] Depression
- [ ] Diabetes
- [ ] Eczema
- [ ] Fibromyalgia
- [ ] Gastro-esophageal Reflux Disease (GERD)
- [ ] Glaucoma
- [ ] Gout
- [ ] Hemorrhoids
- [ ] Hepatitis
- [ ] High cholesterol
- [ ] Hypertension/high blood pressure
- [ ] Hypothyroid
- [ ] Insomnia
- [ ] Irritable Bowel Syndrome
- [ ] Kidney stones
- [ ] Liver Disease
- [ ] Lupus
- [ ] Lyme disease
- [ ] Migraines
- [ ] Multiple Sclerosis
- [ ] Osteoporosis
- [ ] Ovarian cysts
- [ ] Panic Disorder
- [ ] PCOS
- [ ] Psoriasis
- [ ] PTSD
- [ ] Rheumatoid arthritis
- [ ] Seizures
- [ ] Sickle cell disease
- [ ] Skin cancer
- [ ] Sleep apnea
- [ ] Transient ischemic attack
- [ ] Other

If you answered other above, please explain:

Please list any surgeries you have had in the past:

Do any of your immediate family members have health conditions? (Only include grandparents, parents, siblings, and children)

Has anyone in your family had cancer, including grandparents, parents, siblings, and children?

If you work outside the home, what do you do and where do you work?

How many days out of the week do you exercise?

How many meals do you eat daily?

Do you drink caffeine? If yes, how many cups daily?

- [ ] Yes
- [ ] No
- [ ] 1 cup daily
- [ ] 2 cups daily
- [ ] 3 cups daily
- [ ] More than 3 cups daily

Do you smoke? If yes, for how long and how many packs per day?

If you smoke, you should know smoking can lead to many health conditions including but not limited to stroke, diabetes, cancer, heart disease, and chronic obstructive pulmonary disease. I highly advise smoking cessation. Are you interested in discussing ways to stop smoking?

- [ ] yes
- [ ] no

Do you drink alcohol? If yes, how often and how much?

Do you use any drugs or substances not prescribed to you?

Please list any medications you are currently taking. If you are taking more than 5, type "see list" and provide a list at your appointment.

Are you taking any over the counter medications or supplements? If yes, what are you taking and how often?

Are you allergic to any medications?

Have you ever been hospitalized? If yes, when and why?

Who is currently your primary care provider?

Are you under the care of any specialists (cardiologist, endocrinologist, etc.) If yes, who and what specialty?

Have you had any illnesses or been on antibiotics for any reason in the last 3 months? If yes, please explain.

Recommended Screenings

Please leave the question blank if it does not apply to you.

1. Are you a male over 64 who has smoked cigarettes at some point now or in the past?
   - [ ] yes
   - [ ] no

2. Are you taking a daily aspirin?
   - [ ] yes
   - [ ] no

3. Are you currently pregnant or is there a chance you could be pregnant?

☐ yes ☐ no

4. Are you a female who has either personally had or have had family members with breast, ovarian, tubal, or peritoneal cancer?

☐ yes ☐ no

5. If you are a female aged 50 to 74, do you know any details surrounding your last mammogram?

6. Are you currently breastfeeding?

☐ yes ☐ no

7. If you are a female aged 21 to 65, do you know when your last pap smear was completed?

8. If you are sexually active, have you recently been with any new partners recently?

☐ yes ☐ no

9. If you are age 45 or older, do you know any details surrounding your last colonoscopy (date, findings, recommendation, where it was performed)

10. Are you having any of the following symptoms?

☐ sadness ☐ hopelessness ☐ guilt ☐ changes in sleeping habits ☐ excessive crying
☐ irritability ☐ restlessness ☐ mood swings
☐ loss of interest in activities you once enjoyed ☐ appetite changes ☐ fatigue
☐ lack of concentration ☐ weight change ☐ none of these

11. If you are 65 or older, have you had any recent falls?

☐ yes ☐ no

12. Do any of the following apply to you?

- [ ] Aged 40 to 75 years
- [ ] high blood pressure
- [ ] high cholesterol
- [ ] diabetes
- [ ] obesity/overweight
- [ ] smokes cigarettes
- [ ] sedentary lifestyle
- [ ] male
- [ ] family history of heart disease

13. Do any of the following apply to you?

- [ ] I am not vaccinated against Hepatitis B
- [ ] I have injected drugs in the past or currently
- [ ] I am a man who has or has had sex with men
- [ ] I have HIV
- [ ] I have a household member known to be positive for Hepatitis B
- [ ] None of these

14. If you are 18-79 years old, have you been previously tested for Hepatitis C?

- [ ] yes
- [ ] no
- [ ] I don't know

15. If you are 18-79 years old, have you been previously tested for HIV? If yes, check the options that apply to you.

- [ ] yes
- [ ] no
- [ ] I don't know
- [ ] injection drug use
- [ ] transactional sex or commercial sex work
- [ ] having 1 or more new sex partners whose HIV status is unknown
- [ ] live/work/receive medical care in a high-prevalence setting such as a sexually transmitted disease clinic/tuberculosis clinic/correctional facility/homeless shelter
- [ ] None of these

16. Do you have a blood pressure cuff at home?

- [ ] yes
- [ ] no

17. Do any of the following apply to you?

- [ ] Live or work in a high-risk congregate settings like a homeless shelters or correctional facilities
- [ ] healthcare worker
- [ ] Traveled out of the country in the last year
- [ ] None of these

18. If you currently or previously smoked cigarettes, how many packs per day and for how many years?

19. If you are a postmenopausal woman, do any of the following apply to you?

- [ ] parental history of hip fracture
- [ ] smoking
- [ ] excessive alcohol consumption
- [ ] low body weight
- [ ] none of these

20. If you are a woman over 65, when was your last bone mineral density (DEXA) scan?

21. Have you ever been told you have prediabetes or diabetes?

- [ ] yes
- [ ] no

22. Do you wear sunscreen when out in the sun?

- [ ] yes
- [ ] no

23. Do you tan in a tanning bed?

- [ ] yes
- [ ] no

24. If you currently smoke cigarettes, would you like to discuss options to help you stop smoking?

- [ ] yes
- [ ] no

25. Does anyone in your life have concerns about your alcohol intake?

- [ ] yes
- [ ] no

Diabetes

If you have diabetes, please complete these questions:

Do you have any sores, open areas, or dark areas on your feet?

- [ ] Yes
- [ ] No

When was your last eye exam?

How often do you check your blood sugar?

When was your last A1c? Do you know what it was?

Do you have any numbness or tingling in your hands or feet?

- [ ] Yes
- [ ] No

Have you had any low blood sugars since your last medical appointment?

- [ ] Yes
- [ ] No

Have you had your yearly microalbumin check?

- [ ] Yes
- [ ] No

Vaccines

Your decision whether or not to receive vaccinations will always be fully supported by ALL staff of Smart Health and Wellness, PLLC. This is only for informational purposes.

When was your last tetanus injection?

- [ ] Within the last 5 years
- [ ] 5 to 10 years ago
- [ ] More than 10 years ago
- [ ] I don't know

Have you received the flu shot this year?

- [ ] Yes
- [ ] No, and I would like information about how I can get this.
- [ ] No, and I do not want to receive one.

Have you been vaccinated against Covid-19?

- [ ] Yes, I am fully vaccinated and have received a booster if one is due.
- [ ] Yes, I am fully vaccinated but have not received a booster and it is due.
- [ ] No. I would like information on where I can be vaccinated.
- [ ] No. I do not wish to be vaccinated.

Have you received your pneumococcal vaccination? If not, do any of the listed conditions apply to you?

- [ ] Yes
- [ ] No
- [ ] I don't know
- [ ] Age 65 or older
- [ ] Immune deficiency or immunosuppressed
- [ ] Chronic Kidney Disease
- [ ] Malignancy
- [ ] HIV
- [ ] Hodgkin disease
- [ ] Leukemia
- [ ] Lymphoma
- [ ] Multiple Myeloma
- [ ] History of solid organ transplant
- [ ] Congenital or acquired Asplenia
- [ ] Sickle Cell Disease
- [ ] Cerebrospinal fluid leak
- [ ] Cochlear implant

If you are age 50 or older, have you been vaccinated against shingles?

- [ ] Yes
- [ ] No
- [ ] I don't know

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