Patients Name:_____ **Birthdate:**_____

PLEASE MARK "YES" TO ANY CURRENT HEALTH ISSUES

Do you Use Tobacco	O Yes	Racing/ irregular heart beat	O Yes	Incontinence	O Yes
Do you Use Alcohol	O Yes	Chest pain	O Yes	Urine frequency	O Yes
Fatigue/Change in energy	O Yes	Swelling of ankles	O Yes	Burning/pain with urination	O Yes
Fever	O Yes	Pains in leg while walking	O Yes	Joint stiffness	O Yes
Change in sleep	O Yes	Abdominal pain	O Yes	Leg cramps	O Yes
Night Sweats	O Yes	Nausea/vomiting	O Yes	Muscle aches	O Yes
Unexplained Weight Loss	O Yes	Diarrhea	O Yes	Painful /swollen joints	O Yes
Change in Hearing	O Yes	Heartburn or Indigestion	O Yes	Headache/Migraines	O Yes
Change in vision	O Yes	Constipation	O Yes	Tingling/numbness	O Yes
Hoarseness	O Yes	Black stool/blood in stool	O Yes	Memory loss	O Yes
Nasal/sinus congestion	O Yes	Difficulty Swallowing	O Yes	Dizziness	O Yes
Allergies	O Yes	Hot flashes	O Yes	Fainting or Passing out	O Yes
Excessive thirst	O Yes	Abnormal vaginal discharge	O Yes	Balance/coordination issues	O Yes
Shortness of breath	O Yes	Vaginal dryness	O Yes	Weakness	O Yes
Cough	O Yes	Erectile Dysfunction	O Yes	Anxiety	O Yes
Wheezing	O Yes	Decreased force of urine stream	O Yes	Depression	O Yes
Asthma	O Yes	Blood in Urine	O Yes	High stress level	O Yes

Do you skip doses or try to "Stretch out" your medictions due to concerns about the cost? O Yes/ O No

Are you eating less than you feel you should because there wasn't enough money for food? O Yes/ O No

Do you skip healthcare appointments because you don't have a way to get there? O Yes/ O No

Are you having trouble paying your heat or electric bill? O Yes/ O No

Are you worried that in the next 2 months you may not have stable housing? O Yes/ O No

If you checked yes to any boxes above, would you like to receive assistance with any of these needs? O Yes / O No

If you are **50 years of age or older**, please select a response for any falls within the past year.

Have you fallen in the last year	O Yes	O No
One fall with injury in the past year	O Yes	O No
Two or more falls with injury in the past year	O Yes	O No
One fall without injury in the past year	O Yes	O No
Two or more falls without injury in the past year	O Yes	O No

If you are diabetic when was your last eye exam:_____ Where:_____

Please list any NEW drug allergies that have developed in the last year: _____

Please list any surgeries, major procedure or hospitalizations in the last year:_____

Do you need prescription refills: Y / N Which Pharmacy: _____

Doctor/ Nurse Practitioner signature: _____ today's date: _____