UB|MD INTERNAL MEDICINE

ANNUAL HISTORY AND PHYSICAL INFORMATION UPDATE

Please **take time** *to complete the following information for your medical chart. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs.*

Please address EVERY section

PATIENT NAME	**BIRTH DATE** / /	**TODAY'S DATE** / /
FORM COMPLETED BY: ☐ Patient ☐ Family Member ☐ Other:		
REASON FOR YOUR VISIT ***(list current symptoms)***		

PHARMACY INFORMATION

Please provide accurate pharmacy information so that we can fill/refill medications you may need.

Local Pharmacy Name: ______________________

Pharmacy Street Address: ______________________

____

Pharmacy Phone #: ______________________

Do you use a **Mail Order Pharmacy**? Y / N

If yes, **Name of Mail Order Pharmacy**:

MEDICATIONS

Include all current medications including prescriptions, infusions, and over-the-counter herbal/vitamins/supplements ***IF NOT ON ANY MEDICATIONS PLEASE CHECK "NONE"***

NAME OF MEDICATION	DOSAGE	HOW OFTEN IS IT TAKEN?	REASON FOR MEDICATION	PHYSICIAN PRESCRIBING THIS MEDICATION
EX: Aspirin	81 MG	Daily, Twice a day, Bedtime etc.	Stroke Prevention	Dr John Doe
☐ **NONE**				

PATIENT NAME	**BIRTH DATE** / /

MEDICAL HISTORY UPDATES *Since your last visit:*

New Allergy (Update): ________________________________ Reaction (Update): __________________________________

Have you had any testing, Emergency Room, or Urgent care visits? ☐ No ☐ Yes - If yes, please list below

WHERE	REASON	DATE

Have you seen any specialist lately? ☐ No ☐ Yes - If yes, please list below

SPECIALIST	REASON	DATE

FAMILY HISTORY *Please complete the following information about yourself.*

Has anything changed with the health of your family member (including parents, siblings, or children)? ☐ No ☐ Yes

If yes, please explain:

PERSONAL HISTORY *Please complete the following information about yourself.*

Current occupation: ____

Have you ever worked in a job where you were exposed to hazardous environment or chemicals? Y / N

Personal Habits: *(please check all that apply)*

☐ Currently use tobacco/nicotine products: Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco

☐ Other Amount / day: _______________ Years: __________

☐ Former smoker: Amount / day: _______________ Years: __________ Quit Date: _______________

☐ Never smoked

☐ Consume alcohol: Y / N Type: ____________________________________ Amount / day: ________________________

☐ Use recreational drugs: Y / N Type: ________________________________ Frequency: __________________________

Do you exercise at least 20-30 minutes 3 times per week: Y / N If yes, how often: _________________________________

Living Situation/Circumstances:

Do you live alone? Y / N If No, with whom do you live? ____

Do you have a caregiver? Y / N If Yes, whom: ____

Are you someone's caregiver? Y / N If Yes, for whom: ____

Do you have a good support network of family/friends? Y / N If No, please explain:

____

Do you have any communication needs due to hearing, seeing or other issues such as memory or difficulty understanding or reading? Y / N If Yes, please explain: ____

Do you have any cultural needs or beliefs that affect your health care needs? If Yes, please explain:

____

Do you have a health care proxy? Y / N / Not Sure

Do you have an advanced care directives? Y / N / Not Sure

Would you like to discuss planning Advance Directives at your visit? Y / N

PATIENT NAME	BIRTH DATE / /

PERSONAL HABITS

Please complete the following information about yourself.

Do you wear a seatbelt? Always / Occasionally / Never

Do you talk/text on phone while driving? Y / N

Do you have a smoke detector? Y / N

Do you have a carbon monoxide detector? Y / N

Do you have any unsecured guns in the home? Y / N

Would you like to be screened for HIV or sexually transmitted diseases? Y / N

Do you eat 5 or more servings of fruit and vegetables most days? Y / N

IMMUNIZATIONS & PREVENTIVE SERVICES

Since your last visit please check all that apply and PROVIDE DATE received.

	DATE/Yr.		DATE/Yr.		DATE/Yr.
☐ **NONE**		☐ Last bloodwork	______	☐ PAP smear	______
☐ Flu vaccine	______	Where: ______		☐ Mammogram	______
☐ MMR	______	☐ HIV Testing	______	Where: ______	
☐ Tetanus	______	☐ Hepatitis C Testing	______	☐ Bone density test	______
☐ Prevnar vaccine	______	☐ STD Testing	______	☐ Colonoscopy	______
☐ Pneumovax 23 vaccine	______	☐ Hearing test	______	Where: ______	
☐ Hepatitis B vaccines	______	☐ Eye exam	______	Who: ______	
☐ HPV vaccine	______	☐ Dental exam	______	☐ Abdominal Aortic Aneurysm Screening	
☐ Hepatitis A vaccines	______	☐ OTHER ______		Date/Yr: ______	
☐ Zoster Vaccine	______	☐ OTHER ______		Where: ______	

PHQ-2

Please complete the following information about yourself.

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

1) Little interest or pleasure in doing things: ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

2) Feeling down, depressed, or hopeless: ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

GOAL SETTING

Please complete the following information about yourself.

What are your healthcare goals for this year? (Examples include: exercise 3 days per week; be able to kneel down and play with my grandchildren.) ______________________________

How do you plan to accomplish these goals? ______________________________

What are the barriers, if any? (Examples include lack of healthy food, knowledge, lack of outside exercise or play time, no safe outside environment, family distractors, genetics)

____

____

SIGNATURE

______________________________ ______________

Signature **Date**

If completed by someone other than the patient:

Your Name:______________________________ **Relationship:**______________