ADVANCED PRACTICE CLINICIAN – HISTORY & PHYSICAL

Name:	**Date of Birth:**	**Age:**
Occupation/Employer:	**Highest Level of Education:**	
Reason for visit:		
Hospitalizations: Chronic Conditions or Prior Mental Health Treatment		
Illness/Operation – Year		
Chronic Condition(s) **Prior Mental Health Treatment:** ☐ yes ☐ no		
Family & Medical History		
Please check if you or anyone in your family have or had any of the following problems.		
EYES: ☐ glaucoma ☐ cataracts ☐ Vision: ☐ blurred ☐ double ☐ Last eye exam:		
EARS: ☐ hearing loss ☐ ringing ☐ excess wax		
NOSE: ☐ bleeding ☐ congestion/dryness ☐ polyps ☐ **SINUSES:** ☐ pain ☐ congestion		
MOUTH/THROAT: ☐ freq. infections ☐ hoarseness ☐ bleeding gums ☐ bad taste ☐ dry ☐ dental problems		
HAYFEVER/ALLERGIES: ☐ food ☐ pollen ☐ dust ☐ animals ☐ other		
LUNGS: ☐ asthma(wheezing) ☐ bronchitis ☐ pneumonia ☐ emphysema		
SHORTNESS OF BREATH: ☐ on exertion ☐ lying flat		
BREATHING: ☐ slow ☐ irregular ☐ fast ☐ chronic cough ☐ cough(with blood)		
HEART/CIRCULATION: ☐ pain(angina) ☐ heart attack ☐ high blood pressure ☐ heart failure ☐ high cholesterol **Last test:______** ☐ murmurs **PULSE:** ☐ irregular ☐ racing ☐ palpitations ☐ swollen ankles ☐ calf pain ☐ cold/numb feet – fingers ☐ varicose veins ☐ phlebitis		
GASTRO INTESTINAL: Appetite: ☐ good ☐ bad ☐ difficulty swallowing ☐ heartburn ☐ peptic ulcer Frequent: ☐ nausea ☐ vomiting ☐ gall stones ☐ jaundice/hepatitis ☐ changes in bowel habits ☐ chronic constipation ☐ freq. diarrhea ☐ colitis ☐ crohn's ☐ diverticulosis ☐ malabsorption disease ☐ Bloody/black stools **Cancer test date:_______** ☐ hemorrhoids ☐ anal itching/discharge ☐ hernia		
URINARY: ☐ urination(more than twice a night) ☐ urgency to urinate ☐ leakage w/exercise or movement ☐ decrease in flow ☐ painful ☐ overactive bladder ☐ blood in urine ☐ infections ☐ kidney stones **Males:** ☐ prostate **Last test date:_______**		
CANCER: ☐ past ☐ present **Type:________________________** ☐ recent weight loss ☐ easily fatigued		
BLOOD: ☐ anemia ☐ bleeding disorder ☐ bruise easily ☐ have received blood transfusion		

ENDOCRINE: □ diabetes □ thyroid □ osteoporosis (brittle bones)
BONES/JOINTS: □ Arthritis □ rheumatoid □ osteoarthritis □ back pain □ bone fracture/joint injury □ bursitis/tendonitis □ gout □ fibromyalsia
SKIN: □ rashes □ chronic itching □ hives □ eczema □ psoriasis □ excess. sweating □ warts □ nail fungus/discoloration
NEURO: □ headaches □ migraines □ seizures □ stroke □ memory loss □ Parkinson's □ sensory loss □ freq. falls □ vertigo
MENTAL: □ depression □ anxiety □ mood swings □ behavior change □ personality change/disorder □ substance abuse □ phobias □ ADHD □ Hallucinations □ schizophrenia □ concentration problems THOUGHTS OF: □ death □ suicide
INFECTIONS: □ rheumatic fever □ tuberculosis Last Test Date:_______ □ herpes □ AIDS/HIV □ sexually transmitted diseases
WEIGHT: □ eating problems Wish to: □ gain □ lose
SLEEP: □ sleep apnea □ snoring □ restless leg syndrome **Sleeping:** □ too little □ too much
SEX PROBLEMS: □ wish to discuss
ALCOHOL: oz/week_____ **Coffee/Tea** cups a day_____ **Smoking:** cig/day_____ #of years ______ year quit______ **DRUGS:** □ non-prescription □ abused
EXERCISE: routine:______________ **Street Drugs**_________ **TRAVEL ABROAD** Last 12 months: □ yes □ no
FEMALES: **Menstrual Flow:** □ regular □ irregular □ pain/cramps days of flow_____ length of cycle_____ 1st day of last period______ □ pain/bleeding after sex # of pregnancies____ abortions_____ Miscarriages_____ live births _____ birth control method______ __ □ flushing/menopause **Last PAP test date**_________ □ normal □ abnormal **Breasts:** regular self examination □ yes □ no □ nipple discharge **Last mammogram date:** _________ □ normal □ abnormal

PATIENT HEALTH QUESTIONNAIRE

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are asked to skip over a question.

Patient Name: ______________________________

1. During the last 4 weeks, how much have you been bothered by any of the following Problems?	Not Bothered	Bothered a little	Bothered a lot	
a) Stomach pain	☐	☐	☐	
b) Back Pain	☐	☐	☐	
c) Pain in your arms, legs, or joints (knees, hips, etc)	☐	☐	☐	
d) Menstrual cramps or other problems with your periods	☐	☐	☐	
e) Pain or problems during sexual intercourse	☐	☐	☐	
f) Headaches	☐	☐	☐	
g) Chest pain	☐	☐	☐	
h) Dizziness	☐	☐	☐	
i) Fainting spells	☐	☐	☐	
j) Feeling your hear pound or race	☐	☐	☐	
k) Shortness of breath	☐	☐	☐	
l) Constipation, loose bowels, or diarrhea	☐	☐	☐	
m) Nausea, gas, or indigestion	☐	☐	☐	
2. 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
a) Little interest or pleasure in doing things	☐	☐	☐	☐
b) Feeling down, depressed, or hopeless	☐	☐	☐	☐
c) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d) Feeling tired or having little energy	☐	☐	☐	☐
e) Poor appetite or over eating	☐	☐	☐	☐
f) Feeling bad about yourself – or that you are a failure or have let yourself/family down	☐	☐	☐	☐
g) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h) 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	☐	☐	☐	☐
i) Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

PATIENT HEALTH QUESTIONNAIRE (PHQ)

		No	Yes		
3.	**Questions about Anxiety** **In the last 4 weeks, have you had an anxiety attack – suddenly feeling fear or panic?**	☐	☐		
a)	Has this ever happened before?	☐	☐		
b)	Do some of these attacks come suddenly out of the blue - that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐		
c)	Do these attacks bother you a lot or are you worried about having another attack	☐	☐		
4.	**Think about your last anxiety attack.**	No	Yes		
a)	Were you short of breath?	☐	☐		
b)	Did your heart race, pound or skip?	☐	☐		
c)	Did you have chest pain or pressure?	☐	☐		
d)	Did you sweat?	☐	☐		
e)	Did you feel as if you were choking?	☐	☐		
f)	Did you have hot flashes or chills?	☐	☐		
g)	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐		
h)	Did you feel dizzy, unsteady, or faint?	☐	☐		
i)	Did you have a tingling or numbness in parts of your body?	☐	☐		
j)	Did you tremble or shake?	☐	☐		
k)	Were you afraid you were dying?	☐	☐		
5.	**Over the 4 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 everyday
a)	Feeling nervous, anxious, on edge, or worrying a lot about different things				
b)	Feeling restless so that it is hard to sit still	☐	☐	☐	☐
c)	Getting tired very easily	☐	☐	☐	☐
d)	Muscle tension, aches, or soreness	☐	☐	☐	☐
e)	Trouble falling asleep or staying asleep	☐	☐	☐	☐
f)	Trouble concentrating on things, such as reading a book or watching television	☐	☐	☐	☐
g)	Becoming easily annoyed or irritable	☐	☐	☐	☐