Schodack Internal Medicine and Pediatrics

Annual Physical Date:_____

Please Fill out this form (or have your caregiver complete it) and discuss with your medical provider. Thank you!
Please Mark the preferred phone number you want use to contact you.

Patient Name: _____ Date of Birth: _____

Pronouns:_____

Current Concerns/ Changes in Surgical history/ Changes in Family History?: _____

_____

_____

_____

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_____

Review of Systems: Do you currently have concerns with any of the following?

Vision Problems	Yes	No	Leg Swelling	Yes	No	Muscle/Joint Pains	Yes	No
Hearing Problems	Yes	No	Leg pain with walking	Yes	No	Memory Problems	Yes	No
Headaches	Yes	No	Abdominal Pain	Yes	No	Depression	Yes	No
Dizziness	Yes	No	Heartburn	Yes	No	Anxiety	Yes	No
Chest Pain	Yes	No	Difficulty Swallowing	Yes	No	Urine Incontinence	Yes	No
Palpitations/ Irregular pulse	Yes	No	Constipation	Yes	No	Frequent Urination	Yes	No
Shortness of Breath	Yes	No	Recurrent Diarrhea	Yes	No	Blood in Urine	Yes	No
Persistent Cough	Yes	No	Blood in stool	Yes	No	Snoring	Yes	No
Unintentional Weight Loss/ Weight Gain	Yes	No	Night Sweats/ Fever	Yes	No	Loss of Sex Drive	Yes	No
			Skin Problems	Yes	No			

Patient signature: _____

Provider signature:_____

Date: _____

Name:_____ Date of Birth: _____

PHQ-9

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

Alcohol: One Drink =  12oz of Beer  5oz Wine  1.5 oz liquor (one shot)

	None	1 or more
Males: How many times in the past year have you had 5 or more drinks in a day?		
Females: How many times in the past year have you had 4 or more drinks in a day?		

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?		

Patient signature: _____

Provider signature:_____

Date: _____

Name:_____ Date of Birth: _____

Name:_____ Phone number: _____

Preferred Language:_____ Best time to call:_____

		YES / NO
	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work** or study? *(leave blank if you do not have children)*	Y N
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Are you **afraid you might be hurt** in your apartment building or house?	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N
	**Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight	Y N

Patient signature:_____ Date:_____

Provider signature:_____ Date:_____

Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Patient signature:_____ Date:_____

Provider signature:_____ Date:_____