TORRANCE MEMORIAL
PHYSICIAN NETWORK

ADULT PHYSICAL HEALTH QUESTIONNAIRE

Please update any changes that have occurred in the last year.

Name: ___________________________________ Today's Date: _______________ Date of Birth:_______________

Changes in Medications? ☐Yes ☐ No

(New medications prescribed since your last visit or changes in dosage. Please list any medications that you are taking including over-the-counter medications, vitamins, laxatives and herbal supplements.)

Medication Name:	Dose:	Taken How/How Often?	Who Prescribed This?

Allergies? ☐ Yes ☐ No Allergy: ____________________ Reaction:___________________________

Allergy: ____________________ Reaction:___________________________

Past Medical and Surgical History: (Please list most recent first)

Surgery	Year	Hospitalization	Year

Your Specialists: (Please list those you currently see or have seen)

Name	Specialty	Name	Specialty

Immediate Family History: (Please note the following diseases: Cancer, Diabetes, High Blood Pressure, Heart Trouble, Stroke, Seizures, Thyroid Disorder, Mental Disorders, Asthma, Osteoporosis, Tuberculosis.)

Family:	Age (if living)	Deceased: (note age and cause)	Healthy or noted Illness(es):	Additional Siblings with age and condition:
Father:				
Mother:				
Brother:				
Sister:				
Son:				
Daughter:				

☐ ***Please check if you have written additional information on the back of the page.***

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Name: ______________________________ Today's Date: ____________ Date of Birth: ____________

Social History

Preferred Language: ______________________ Need Interpreter? ☐ Yes ☐ No

Currently Employed: ☐Yes ☐ No ☐ Retired

Occupation: ______________________ Hours worked per week: ______________________

Is your work satisfying and free from undue pressure or stresses? ☐Yes ☐ No

Do you miss much time from work? ☐Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
# of Previous Marriages: ________

How is your relationship with your spouse? ______________________________________

Is your sex life satisfying? ☐Yes ☐ No

How is your relationship with your children? ______________________________________

Number of Children: ___________Girls __________ Boys

Do you give or receive ongoing care at home? ☐Yes ☐ No To or from whom?______________________
Do you have an advanced directive? ☐Yes ☐ No
Does this office have a copy on file? ☐Yes ☐ No

Smoking: ☐ Never ☐ Former ☐ Yes, # of Packs/Day: ______________ # of Years Smoked: ______________

Alcohol: ☐ Never ☐ Former ☐ Yes, # of Drinks/Week: ______________ Type: ______________________

Illicit Drugs: ☐ Never ☐ Former ☐ Yes Type: ______________________

Caffeine Intake: ☐ Yes ☐ No
☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Chocolate Daily Intake: __________

Lifestyle: Are you on a specific diet? ☐Yes ☐ No If yes, which type of diet? ______________________
Do you exercise regularly? ☐Yes ☐ No If yes, what type of exercise: ______________________
Number of days per week: ______________________
Hours per day: ______________________

Preventive Care: (please give date of last exam)

Exams:	Date:	Screenings:	Date:	Vaccines:	Date:	Other	Date:
Physical Exam	_______	Diabetic Screen	_______	Tdap	_______	**Female Only:**	
Dental Exam	_______	Lipid Panel	_______	Gardasil	_______	Pap Smear	_______
Eye Exam	_______	Colonoscopy	_______	Hep A	_______	Mammography	_______
EKG	_______	Bone Density	_______	Hep B	_______		
		TB Test	_______	Influenza	_______	**Male Only:**	
Diabetics Only:		STD Testing	_______	Pneumonia	_______	PSA	_______
Hemoglobin A1C	_______		_______	Zostavax (shingles)	_______		
Urine Micro Alb	_______						
Foot Exam	_______						

Do you take aspirin 81mg daily? ☐Yes ☐ No

☐ ***Please check if you have written additional information on the back of the page.***

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Name: ______________________________ Today's Date: ____________ Date of Birth:_____________

Please mark any of the following conditions that you may have on a recurrent basis.
Answer all questions that apply.

General:
- ☐ Fatigue
- ☐ Fever
- ☐ Chills or night sweats
- ☐ Weight gain
- ☐ Weight loss

Head, Eyes, Ears, Nose, Throat:
- ☐ Eye pain or injury
- ☐ Itching or eye redness
- ☐ Vision: Loss/Blurry/Double

- ☐ Ear pain or discharge
- ☐ Hearing loss
- ☐ Ringing in ears/Tinnitus
- ☐ Dizziness
- ☐ Fainting spells

- ☐ Bleeding nose
- ☐ Runny nose/sneezing/itching
- ☐ Sinus pressure

- ☐ Bleeding gums
- ☐ Sore Throat
- ☐ Painful swallowing

Neck:
- ☐ Stiffness or injury
- ☐ Enlarged glands

Respiratory:
- ☐ Wheezing
- ☐ Difficulty breathing
- ☐ Frequent colds
- ☐ Chronic or frequent cough
- ☐ Bloody sputum
- ☐ Asthma
- ☐ Seasonal or environmental allergies

Cardiovascular:
- ☐ Chest pain
- ☐ Chest pressure
- ☐ Heart murmur
- ☐ Palpitations / Heart skips
- ☐ Shortness of breath w/ exercise
- ☐ Shortness of breath lying down
- ☐ Leg cramps or swelling
- ☐ Varicose veins

Gastrointestinal:
- ☐ Loss of appetite
- ☐ Abdominal pain or cramping
- ☐ Heartburn or indigestion
- ☐ Intolerance to greasy /spicy food
- ☐ Vomiting food
- ☐ Vomiting blood
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Pain with bowel movements
- ☐ Blood in stool or black stool
- ☐ Hemorrhoids

Genitourinary:
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Urine frequency or urgency
- ☐ Loss of urine w/ cough or sneeze
- ☐ Decrease in strength of stream
- ☐ Nighttime urination:
- ☐ # of times __________

Gynecological (Women Only)**:**
- ☐ Vaginal discharge
- ☐ Pain with menstruation
- ☐ Pain with sexual relations
- ☐ Age when period started: __________
- ☐ How long do periods last?_______days
- ☐ Are periods regular: ☐ Yes ☐ No
- ☐ Age at menopause: _____
- ☐ Number of pregnancies: _____
- ☐ Number of miscarriages: _____
- ☐ Number of abortions: _____
- ☐ Number of children: _____
- ☐ Do you take Folic Acid?☐ Yes ☐ No

Locomotor-Musculoskeletal:
- ☐ Pain in neck or back
- ☐ Joint pain or swelling
- ☐ Muscle pain or weakness
- ☐ Difficulty walking
- ☐ Balance problems
- ☐ Pain while walking

Neuro-Psychiatric:
- ☐ Seizures ☐ Convulsions
- ☐ Tremors
- ☐ Extremity numbness, tingling
- ☐ Problems with balance or gait
- ☐ Memory problems
- ☐ Headaches or migraines
- ☐ Trouble sleeping ☐ Insomnia
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Loss of interest
- ☐ Hallucinations

Hematologic:
- ☐ Excessive bleeding
- ☐ Abnormal bruising
- ☐ Slow to heal after cuts

Skin:
- ☐ Frequent infections or boils
- ☐ Hives/eczema/rash
- ☐ Moles that are changing
- ☐ Skin Cancer:
  - ☐ Basal cell / ☐ Squamous cell
  - ☐ Melanoma
- ☐ Keloids
- ☐ Skin allergies:
  Latex or Tape
  Other: ___________________

Endocrine:
- ☐ Hormone therapy
- ☐ Hot Flashes
- ☐ Hot or cold intolerance
- ☐ Excessive thirst
- ☐ Change in texture hair or skin

Male Reproductive:
- ☐ Erectile Dysfunction
- ☐ Testicular pain or mass
- ☐ Penile discharge

____
Date

____
Patient Signature

____
Provider Signature

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Name: ________________________________ Today's Date: ______________ Date of Birth:______________

Depression Screening Test (PHQ-9)

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

(Please circle the number 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	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or over eating	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 notice. Or the opposite – being so fidgety or restless that you have to move around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	Add columns:	+	+	
	(Add totals for the 3 columns)		**Total**	=

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Alcohol Screening Test

Please mark your answer. Points are posted next to your answer. Add up total at bottom of section.

1. **How often do you have a drink containing alcohol?**
   ☐ Never (0.0) ☐ Monthly or less (0.5) ☐ 2-4 times a month (1.0) ☐ 2-3 times a week (1.5) ☐ 4 or more times a week (2.0)
2. **How many drinks containing alcohol do you have on a typical day when you are drinking?**
   ☐ 1 or 2 (0.0) ☐ (0.5) 3 or 4 ☐(1.0) 5 or 6 ☐ (1.5) 7 to 9 ☐ (2.0) 10 or more
3. **Have people annoyed you by criticizing your drinking?**
   ☐ No (0.0) ☐ Yes (1.0)
4. **Have you ever felt bad or guilty about your drinking?**
   ☐ No (0.0) ☐ Yes (1.0)
5. **Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?**
   ☐ No (0.0) ☐ Yes (1.0)

Score: ___________ A score of 2.5 or greater indicates possible misuse and the need for further evaluation. Please fill out the Alcohol Audit Form.

PROVIDER INITIALS ___________

TORRANCE MEMORIAL PHYSICIAN NETWORK

Senior Wellness and Health Questionnaire

(Please only complete this form if you are ***65 or older****)*

Name: ________________________________ Today's Date: ______________ Date of Birth:______________

Completed By: __________________________ Relationship:____

Do you ever have trouble with any of these daily activities?
(Please mark your answer)

- ☐ Yes ☐ No Taking medication
- ☐ Yes ☐ No Getting dressed independently
- ☐ Yes ☐ No Taking a bath or shower independently
- ☐ Yes ☐ No Walking
- ☐ Yes ☐ No Urine Continence
- ☐ Yes ☐ No Bowel Continence

Are you able to do the following functions?
(Please mark your answer)

Home Safety:
(Please mark your answer)

Easy	Difficult	Unable				
☐	☐	☐	Climb stairs	Have you fallen in the last year?	☐ Yes	☐ No
☐	☐	☐	Exercise	If so, how many times? ____________		
☐	☐	☐	Get in and out of cars	If yes, did you get injured?	☐ Yes	☐ No
☐	☐	☐	Go down stairs			
☐	☐	☐	Go up stairs	Do you regularly wear a seatbelt?	☐ Yes	☐ No
☐	☐	☐	Kneel	Do you have a smoke detector		
☐	☐	☐	Put on socks and shoes	in your home?	☐ Yes	☐ No
☐	☐	☐	Walk 5 to 10 blocks	Do you have a carbon monoxide detector		
☐	☐	☐	Walk an unlimited distance	in your home?	☐ Yes	☐ No

What is your level of Daily Activity? *(Please mark your answer)*

- ☐ Sedentary – Sitting watching or reading for most of the day, no exercise.
- ☐ Moderate – Exercises (walking 2-3 times a week)
- ☐ Vigorous – Exercises daily

Are you suffering from pain? ☐Yes ☐ No

How would you rate your pain on a scale of 0 to 10, with 10 being the most severe pain? __________________________

If yes, what is the location of the pain? ____

Do you have someone designated to make health decisions on your behalf if you could not make decisions for yourself? ☐Yes ☐ No *(Please mark your answer below)*

- ☐ Advanced Directive/Living Will (a written statement of a person's wishes regarding their medical treatment in circumstances in which they are no longer able to express informed consent)
- ☐ Durable Power of Attorney (A document established by an individual granting another person the right and authority to handle matters related to the health care)
- ☐ Healthcare Proxy (A document that allows a patient to appoint an agent to make health care decisions)

Does your physician have a copy in your chart? ☐Yes ☐ No

PROVIDER INITIALS ____________