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:_____

Are you having any problems filling your medications due to their high cost of the medications? ☐Yes ☐ No

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/Supplement:	Dose:	Taken How/How Often?	Who Prescribed This?

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

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:				

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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 ☐ Yes, # of Packs/Day: _____
☐ Former # of Years Smoked: _____

Illicit Drugs: ☐ Never ☐ Yes
☐ Former 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: _____

Alcohol Screening Test

	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If you have a score of 5 or more on the Alcohol Screening Test further questions may be needed.

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PHQ

Circle to indicate your answer		
Have you been diagnosed with Depression in the past 2 years?	NO	YES
Have you been on an anti-depressant medication in the past 2 years?	NO	YES
Over the last 2 weeks have you often been bothered by any of the following problems?		
1) Little interest or pleasure in doing things? (This question asks if you are so depressed that things you normally enjoy doing you no longer want to do)	NO	YES
2) Feeling down, depressed, or hopeless?	NO	YES

STOP: Do not fill out the bottom section if answers to sections above are NO

		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 to much	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 could have noticed. Or the opposite- being so fidgety or restless that you have moving 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:	+	+	+
		TOTAL=			

10)	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 difficult at all	
		Somewhat difficult	
		Very difficult	
		Extremely difficult	