Preventive Appointment – Established Adult

WESTFIELD Family PHYSICIANS, PC

Please fill out these forms and
bring the *completed* forms with you
to your appointment on

_____/_____/_____

at _____:_____ AM / PM

with _____.

When patients do this prior to their visit,
they are seen more promptly on the
day of their appointment.

We appreciate your cooperation
and look forward to seeing you soon!

Everyone should have a Healthcare Proxy in place in the event they are unable to make healthcare decisions for themselves. If you have a Healthcare Proxy in place, please bring a copy to your visit so we can include it in your medical record. Thank you.

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138 E Main St Westfield, NY 14787 716-326-4678 | 115 E Main St Sherman, NY 14781 716-761-6144

WFP Review of Systems Patient Questionnaire

Print your name:_____ Date of birth:_____ Exam Date:_____

➔Please put a check by any problem that you have had in the past year.

GENERAL:
- ☐ Significant weight change
- ☐ Increased thirst
- ☐ Decreased energy
- ☐ None of the above

HEENT:
- ☐ swollen glands
- ☐ eye trouble
- ☐ difficulty hearing
- ☐ ear problems
- ☐ dental / mouth problems
- ☐ frequent nosebleeds
- ☐ allergies or hayfever
- ☐ persistant hoarseness in your voice
- ☐ None of the above

RESPIRATORY / CARDIOVASCULAR:
- ☐ wheezing or shortness of breath
- ☐ frequent cough
- ☐ sweating more than usual or "night sweats"
- ☐ a racing heart or palpitations
- ☐ tightness or pains in your chest
- ☐ swollen feet or ankles
- ☐ Unusual or prolonged fatigue
- ☐ None of the above

GASTROINTESTINAL and GENITOURINARY:
- ☐ heartburn or indigestion
- ☐ abdominal discomfort or pain
- ☐ bouts of nausea or vomiting
- ☐ difficulty swallowing
- ☐ pains in your rectum
- ☐ bowel movements that were bloody or tarry
- ☐ any change in your bowel habits
- ☐ frequent urination during the day or at night
- ☐ uncomfortable or difficult urination
- ☐ loss of bladder or bowel control
- ☐ None of the above

SKIN AND EXTREMITIES:
- ☐ skin problems or any changes in your skin
- ☐ aching muscles or joints
- ☐ lumps or bumps on your body
- ☐ daily pain: where?_____
- ☐ None of the above

NEUROLOGIC:
- ☐ frequent headaches
- ☐ been dizzy, fainted, or had blackouts
- ☐ seizures or convulsions
- ☐ weak or numb arms or legs
- ☐ None of the above

FOR MEN ONLY:
- ☐ a drip or discharge from your penis
- ☐ noticed lumps or swellings on your testicles
- ☐ difficulty with your erection
- ☐ None of the above

FOR WOMEN ONLY:
- ☐ Change in your period
- ☐ Bleeding between periods
- ☐ Vaginal bleeding after menopause
- ☐ Pain during sex
- ☐ Vaginal bleeding after sex
- ☐ Vaginal itching or discharge
- ☐ Problems with your breasts
- ☐ History of an abnormal pap test (within 5 yrs)
- ☐ None of the above

When was your last Pap test? _____
When was your last normal menstrual period?
(mo)_____/(day)_____/yr)_____
What form of birth control do you use?
_____
Number of pregnancies: _____
Number of abortions:_____ Miscarriages: _____

➔ Please answer the following mood screening questions

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

Little interest or pleasure in doing things?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed or hopeless?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling anxious or nervous?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Not able to stop worrying?
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

➔ Lifestyle Questions: Please check yes or no and provide details as requested

Yes	No		Yes	No	
☐	☐	Smoke or chew tobacco _____per day	☐	☐	Eat 3 healthy meals per day
☐	☐	Drink alcohol _____per day	☐	☐	Attend church
☐	☐	Recreational Drug use List:_____	☐	☐	Difficulty with sleep
			☐	☐	Sexual concerns
☐	☐	Regular use of OTC pain medications	☐	☐	Concerns about violence or incest in your home
☐	☐	Exercise regularly/how? _____	☐	☐	Has anyone threatened or harmed you in any way?

Comments or concerns you would like to discuss at your visit:_____

_____

_____ Reviewed by:_____ Date:_____
Signature of patient provider initials

Westfield Family Physicians ***Personal Health Update***

Name: _____Date of Birth_____Exam Date_____

In an effort to support your efforts towards maintaining a healthy lifestyle, we ask that you provide us with the following information.

What is your preferred language? ☐ English ☐ Spanish other _____
Are you hard of hearing? ☐ No ☐ Yes ☐ Hearing Aid
Are you legally blind? ☐ No ☐ Yes

When was your last dental visit? _____

***Please list any specialists you see*:** _____
_____

Please list any other medical services you receive (include home health services, oxygen companies, therapy etc.)

_____

Do you find it difficult to take care of your health due to problems with:
☐ Transportation ☐ Cost (co-pays, healthy food, medications)
☐ Family issues ☐ Understanding ☐ No problems

How confident are you that you can manage your health condition at home? Rate your confidence from 1-10, one being not confident at all, ten being very confident. (Circle your answer)

1 2 3 4 5 6 7 8 9 10

Has anyone in your family had any significant change in their health in the past 5 years? ☐ Yes ☐ No

Details: _____

Have you had any recent change in your health?
☐ Surgery ☐ Hospitalization ☐ Procedure ☐ Injury/accident ☐ none

Details: _____

In the past year, how many days of work have you missed due to personal illness?
☐ 0 ☐ 1-2 days ☐ 3-5 days ☐ 6-10 days ☐ 11 + days

Considering your age, how would you describe your overall physical health? (using a scale of 0-100, rate your health with 0 being terrible and 100 being perfect. Draw a line where you rate your health)

: (0----------10---------20---------30----------40----------50----------60----------70----------80----------90----------100 **:)**

How many hours of sleep do you usually get each night?
☐ 6 hours or less ☐ 7-8 hours ☐ 9 hours or more ☐ Shift work/ sleep _____hrs per day

Have you fallen more than once in the past year? ☐ Yes ☐ No ***Do you worry about falling?*** ☐ Yes ☐ No

Name: _____ Date:_____

In general, how satisfied are you with your life (including personal and professional aspects?)

☐ Completely satisfied ☐ Mostly satisfied ☐ Not satisfied

In general, how strong are your social ties with your family and/or friends?

☐ Very strong ☐ About Average ☐ Weak

Have you, or a close relative suffered a personal loss or misfortune in the past year? (For example: a job loss, divorce or separation, jail term or death of someone close to you)

☐ No ☐ Yes, one instance ☐ Yes, 2 or more instances

Anyone having sexual contacts or sharing drug paraphernalia may be at risk for HIV(AIDS). Other contact with blood or body fluids of an infected person may also pose a risk. (tattoos, piercing, etc) We are now able to do an in-office test for HIV. Would you like to have that test done today?

☐ No ☐ Yes ☐ Not today, but would like more information.

In the next six months are you planning to make any changes to keep yourself healthy or improve your health?

	Yes	No	Don't Know	Not Needed
Increase Physical Activity	__	__	__	__
Lose Weight	__	__	__	__
Reduce alcohol use	__	__	__	__
Quit or cut down smoking	__	__	__	__
Reduce fat/cholesterol intake	__	__	__	__
Cope better with stress	__	__	__	__
Decrease blood pressure	__	__	__	__

Do you have any other questions or concerns that you would like to discuss with your provider?

If we could do any one thing to improve your experience of care at our office, what would it be?

Who is your emergency contact?

Name_____Relationship_____

Phone/address_____

Office use
Reviewed by:_____Date:_____