NAME: _____ DOB: _____ PREVIOUS PCP (new patients only) : _____

PART A: Mood Questionnaire

Over the last 2 weeks how often have you been bothered by any of the following problems:

	Never	Sometimes	Half of the time	Almost Always
1) Little interest or pleasure in doing things	[ ]	[ ]	[ ]	[ ]
2) Feeling down, depressed or hopeless	[ ]	[ ]	[ ]	[ ]
3) **EITHER** trouble falling/staying asleep **OR** sleeping too much	[ ]	[ ]	[ ]	[ ]
4) Feeling tired or having little energy	[ ]	[ ]	[ ]	[ ]
5) **EITHER** poor appetite **OR** overeating	[ ]	[ ]	[ ]	[ ]
6) Feeling bad about yourself or that you are a failure or have let yourself or your family down	[ ]	[ ]	[ ]	[ ]
7) Trouble concentrating on things, such as reading the newspaper or watching TV	[ ]	[ ]	[ ]	[ ]
8) **EITHER** 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	[ ]	[ ]	[ ]	[ ]
9) Thoughts that you would be better off dead or hurting yourself or others in some way	[ ]	[ ]	[ ]	[ ]

PART B: Wellness

Was your last Annual Wellness/Annual Preventative Exam **with your PCP** at least 365 days ago? [ ] Yes [ ] No

When was it? _____ Are you fasting (for the past 6-8 hours)? [ ] Yes [ ] No

Do you have a well balanced diet? [ ] Yes [ ] No Dietary restrictions? _____

List any allergies & reactions you have: _____

Do you exercise? [ ] Yes [ ] No What type(s)? _____ How often? _____

Circle any family history of cancer **before the age of 50** of: breast / colon / ovaries / cervix / prostate Last colonoscopy: _____

FEMALES:

Last mammogram: _____ Last pap smear: _____ History of abnormal pap smear? [ ] Yes [ ] No

Last bone density scan (DEXA): _____ Last menstrual period: _____

PART C: Sleep Quality

1) Are you overweight? [ ] Yes [ ] No
2) Have you been told you snore loudly? [ ] Yes [ ] No
3) Have you been told you stop breathing during sleep? [ ] Yes [ ] No
4) Do you have high blood pressure? [ ] Yes [ ] No
5) Do you feel tired/fatigued during the day? [ ] Yes [ ] No
6) Do you feel irritable all day? [ ] Yes [ ] No
7) Do you sleep restlessly and toss and turn frequently? [ ] Yes [ ] No

Part D: Treatment Team - List all specialists that you follow:

PART E: Chronic Conditions & Medications (NEW PATIENTS ONLY)- list all chronic conditions & the medications that you take for them.

Condition/Diagnosis	Medication name	Dose	Frequency	Who prescribed it?

PART F: Surgeries/Hospitalizations (NEW PATIENTS ONLY)- list all previous surgeries & reasons for previous hospitalizations with dates of occurrence.

*__Insurance does not allow coverage__ for refills or medical concerns/complaints/referral requests as part of **annual preventative/ wellness visits**. These must be billed for an additional visit & **will incur additional co-pay/cost**, which is **determined by your insurance company/plan, not our office.***