Internal Medicine Associates of Middle Georgia
97 Martin Luther King Jr. Drive
Forsyth, Georgia 31029

Craig Caldwell, M.D. **Jeremy T. Goodwin, M.D.**

Today's Date:

1. Name:

2. Address:
   Street Address: Apartment #:
   City/State: Zip:

3. Phone (____) _____

4. What is your date of birth? ____/____/____

5. Sex: ____ Male ____ Female

6. Who filled out this form?
   *Relationship if other than patient?
   Phone (____) _____

7. Who has been your previous primary doctor?
   Name:
   Address:

   Phone (____) _____
   Fax (____) _____

8. Do you plan to continue to be followed by this doctor?
   1. ____ No
   2. ____ Yes
   3. ____ Not sure

PAST MEDICAL HISTORY

9. Which medical conditions do you have or have you had in the past? (Check all that apply)

I. EYE & EAR PROBLEMS

a. ____ Cataracts
b. ____ Glaucoma
c. ____ Macular degeneration of the eye
d. ____ Hearing loss/hearing aid
e. ____ Other, specify:

II. HEART PROBLEMS

a. ____ Heart attack: Year ____
b. ____ Heart failure
c. ____ High blood pressure
d. ____ Irregular heartbeats (Arrhythmias)
e. ____ Other, specify:

III. LUNG PROBLEMS

a. ____ Asthma
b. ____ Bronchitis
c. ____ Emphysema
d. ____ Other, specify:

IV. BONE & JOINT PROBLEMS

a. ____ Arthritis
b. ____ Osteoporosis
c. ____ Fractured hip, wrist or spine (circle which one)
d. ____ Gout
e. ____ Other, specify:

V. GLAND PROBLEMS

a. ____ Diabetes
b. ____ Thyroid overactive (high)
c. ____ Thyroid underactive (low)
d. ____ Other, specify:

VI. KIDNEY & URINARY TRACT PROBLEMS

a. ____ Kidney disease
b. ____ Prostate disease
c. ____ Frequent bladder or kidney infections
d. ____ Urinary incontinence
e. ____ Other, specify:

VII. GASTROINTESTINAL PROBLEMS

a. ____ Ulcers

b. ____ Heartburn/Hiatal hernia
c. ____ Diverticulosis
d. ____ Liver disease/Cirrhosis
e. ____ Hepatitis
f. ____ Polyps
g. ____ Gallbladder disease
h. ____ Other, specify:

VIII. NERVOUS SYSTEM PROBLEMS

a. ____ Stroke
b. ____ Dementia or Alzheimer's Disease
c. ____ Parkinson's Disease
d. ____ Epilepsy or Seizures
e. ____ Other, specify:

IX. OTHER HEALTH PROBLEMS

a. ____ Allergies, specify _____
b. ____ Anemia
c. ____ Hernia
d. ____ Thrombosis (blood clots)
e. ____ Cancer, of what _____
f. ____ Depression
g. ____ Sexual function problems, specify
h. ____ Other, specify

10. List Surgeries (Operations). Use back of page, if needed.

DATE	SURGERY (OPERATIONS)

11. List Other Hospitalizations. Use back of page, if needed.

DATE	REASON

12. Do you have any drug allergies?

1. ____ No
2. ____ YES. → If YES, specify below

NAME OF DRUG	REACTION

13. List all medicines that you use. (Prescriptions, Non-Prescriptions, Natural Products)

Current medications used regularly	What strength?	How do you use it? (How many? How many times a day?)
Example: Tylenol	500mg	1 pill 3 times a day

SOCIAL HISTORY

14. With whom do you live? (check one)

1. ____ Alone
2. ____ Spouse or partner
3. ____ Child or other family member
4. ____ Others, not family
5. ____ Other, specify:

15. Which of the following best describes your residence? (check one)

1. ____ Single-family house
2. ____ Condo or apartment
3. ____ Live with other in their home, condo or apartment
4. ____ Retirement hotel
5. ____ Board and care/residential care facility
6. ____ Nursing Home
7. ____ Other, specify:

16. Are you currently (check one)

1. ____ Married
2. ____ Divorced/Separated
3. ____ Widowed
4. ____ Single/Never married
5. ____ Living with Significant Other

17. How many children do you have? _____

Are you in regular contact with your children? Yes _____ No _____

18. How much school did you complete? (check one)

1. ____ Less than 6th grade
2. ____ Less than high school graduate
3. ____ High school graduate
4. ____ Some college
5. ____ College graduate
6. ____ More than college graduate

19. What has been your principal occupation?

20. Are you currently (check one)

1. ____ Retired/Not working
2. ____ Working part-time
3. ____ Working full-time

21. Do you <u>employ</u> someone to provide care or help you in your home?

1. ____ NO
2. ____ YES → If YES. How many hours a day and how many days a week is your paid helper available for you?
   _____ hours a day and _____ days a week

Is this sufficient to meet your needs

1. ____ NO
2. ____ YES

22. Do you <u>employ</u> someone to provide care or help you in your home?

1. ____ NO
2. ____ YES → If YES, approximately many hours a day and how many days a week is your family member or friend available for you?
   _____ hours a day and _____ days a week

Is this sufficient to meet your needs

1. ____ NO
2. ____ YES

23. Who would you call if you were sick and needed help? _____

24. Do you provide care for a family member?

1. ____ NO
2. ____ YES

25. Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

1. ____ Daily
2. ____ Almost daily (4 to 6 times a week)
3. ____ 1 to 3 times a week
4. ____ Less than 1 time a week
5. ____ Never

26. If you drink alcohol, has anyone ever been concerned about your drinking?

1. ____ NO
2. ____ YES

27. Have you ever smoked cigarettes?

1. ____ NO
2. ____ YES → If YES, Are you now smoking?
   a. ____ no. If no,
      1. How many years ago did you quit?
      2. For how many years did you smoke?
      3. How much did you smoke? ____ pack per day
   b. ____ yes. If yes,
      1. How many years have you smoked?
      2. How much do you smoke? ____ pack per day

FAMILY HISTORY

28. Have any members of your family had any of the following conditions? Check all that apply

1. ____ Dementia or Alzheimer's Disease
2. ____ Cancer, of what?
3. ____ Heart disease
4. ____ Stroke
5. ____ Diabetes
6. ____ Depression
7. ____ None of these

PLANNING FOR FUTURE HEALTH CARE

29. Do you have a medical Durable Power o Attorney?

1. ____ NO
2. ____ YES (If yes, please bring a copy)

30. Do you have a living will?

1. ____ NO
2. ____ YES (If yes, please bring a copy)

31. We want to know if you need help with any of the following, and who helps you. Fill out for each task.

TASK	DON'T NEED HELP	NEED HELP	IF YOU NEED HELP, WHO HELPS? (Name and Relationship)
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing			
Using the telephone			
Taking your medicines			
Preparing meals			
Managing money/financial affairs/checkbook			
Doing laundry			
Doing house work			
Shopping for groceries			
Driving			
Doing "handyman" work			
Climbing a flight of stairs			
Getting to places beyond walking distance			

32. To be certain that we've covered everything, during the last three month, have you had any of the following symptoms or problems? (check all that apply)

I. GENERAL PROBLEMS

a. ____ Weight Loss
b. ____ Weight gain
c. ____ Fevers
d. ____ Chills
e. ____ Sweats
f. ____ Cold or flu
g. ____ Change of appetite

II. EYES

a. ____ Trouble seeing
b. ____ Eye pain
c. ____ Dry eyes

III. EAR, NOSE, MOUTH, THROAT

a. ____ Trouble hearing
b. ____ Ear pain or itching
c. ____ Sinus problems
d. ____ Nose bleeds
e. ____ Sore throat
f. ____ Teeth problems
g. ____ Hoarseness
h. ____ Mouth sores
i. ____ Allergies

IV. HEART PROBLEMS

a. ____ Chest pain or tightness
b. ____ Rapid or irregular heart beat
c. ____ Swelling of feet

V. LUNG PROBLEMS

a. ____ Persistent cough
b. ____ Difficulty breathing or shortness of breath
c. ____ Coughing up blood
d. ____ Wheezing

VI. DIGESTION PROBLEMS

a. ____ Difficulty swallowing
b. ____ Frequent indigestion or stomach ache, heartburn
c. ____ Frequent nausea or vomiting
d. ____ Change in bowel habits
e. ____ Black bowel movement or bleeding from rectum
f. ____ Frequent diarrhea
g. ____ Persistent constipation

VII. BONE AND JOINT PROBLEMS

a. ____ Leg pain on walking

b. ____ Back or neck pain
c. ____ Joint pain or stiffness
d. ____ Foot problems
e. ____ Falls

VIII. BRAIN AND NERVOUS SYSTEM PROBLEMS

a. ____ Frequent headaches
b. ____ Frequent dizzy spells
c. ____ Passing out or fainting
d. ____ Falls
e. ____ Paralysis, leg or arm weakness
f. ____ Numbness or loss of feelings
g. ____ Serious problem with memory or difficulty thinking
h. ____ Tremor or shaking
i. ____ Problems with sleep

IX. MOOD/SADNESS PROBLEMS

a. ____ Depression
b. ____ Anxiety

X. GYNECOLOGY PROBLEMS

a. ____ Vaginal bleeding
b. ____ Breast lumps or discomfort
c. ____ Vaginal discharge

XI. KIDNEY & URINARY TRACT PROBLEMS

a. ____ Urination at night (How many times)
b. ____ Frequent urination
c. ____ Painful urination
d. ____ Difficulty starting or stopping urination
e. ____ Loss of urine or getting wet. If yes, 6 or more times a year?

XII. SKIN PROBLEMS

a. ____ Rash
b. ____ Sores
c. ____ Itching

XIII. MISCELLANEOUS

a. ____ Excessive thirst
b. ____ Feel too hot or too cold
c. ____ Problems with sexual function

If you have had none of the above problems listed in question 32 during the past 3 months, check here _____

HEALTH MAINTENANCE

33. Have you ever had an examination of your bowel with a scope (Circle which one: sigmoidoscopy or colonoscopy)?

1. ____ NO
2. ____ YES → If YES, When did you have your most recent sigmoidoscopy or colonoscopy (Circle which one)?
   ____ (year)

34. Have you had a hearing test within the last two years? Yes _____ No _____

35. Have you had an eye exam within the past year? Yes _____ No _____

36. In the past 12 months, have you had a test for blood in your stool (three cards at home)?

1. ____ NO
2. ____ YES

37. Have you seen a dentist in the last year? Yes _____ No _____

38. Have you ever had the Pneumovax vaccine (a shot to prevent pneumonia)?

1. ____ NO
2. ____ YES

39. Have you ever had a tetanus shot?

1. ____ NO
2. ____ YES → If YES, In what year did you have your last tetanus booster? ____ (year)

40. Have you had a flu shot this season, (October-February)?

1. ____ NO
2. ____ YES
3. ____ Not applicable (March-September)

41. Do you always wear a seatbelt when you ride in a car?

1. ____ NO
2. ____ YES

42. Do you currently participate in any regular activity to improve or maintain your physical fitness? (either on your own or in a formal class)

1. ____ NO
2. ____ YES → If YES, check what you do currently.
   a. ____ Walking
   b. ____ Swimming
   c. ____ Aerobics or exercise classes
   d. ____ Dancing
   e. ____ Jogging
   f. ____ Bicycling or stationary bike
   g. ____ Tennis
   h. ____ Golf
   i. ____ Bowling or bocce
   j. ____ None of the above
   k. ____ Other, specify

ANY PROBLEMS WITH FALLING?

43. Are you afraid of falling? No ____ Yes ____

44. Have you had a fall in the past year?

No ____ (**STOP**. You do not need to fill out the rest of the page. Please turn to next page).
Yes ____ (Please continue with question 45 through 46)

45. Please tell us about your last 2 falls

a. If you have had less than 2 falls, just tell us about the one you have had.
b. To describe the circumstances of each fall, please tell us: what you were doing when you fell, what you think caused the fall, whether you experienced light-headedness or palpitations, how you landed (front/back/side), if there was loss of consciousness, and anything else you think is important.

MOST RECENT FALL

a. Date (as best you can): Month _____ Year _____
b. How did this fall happen (briefly describe circumstances): _____
_____
_____
c. Did you need to see a doctor or other professional for treatment after this fall?
No _____ Yes _____
_____
_____

PRIOR FALL

____ Check here if not applicable (If you have only had one fall)
a. Date (as best you can): Month _____ Year _____
b. How did this fall happen (briefly describe circumstances): _____
_____
_____
c. Did you need to see a doctor or other professional for treatment after this fall?
No _____ Yes _____
_____
_____

46. Do you use a walking aid such as a cane or walker? No ____ Yes ____

Men proceed to question 47; women skip to question 49.

QUESTIONS FOR MEN ONLY

(After completing question 48 please go to question 52)

47. Have you ever had a prostate exam (rectal exam)?

1. ____ NO
2. ____ YES → **If YES, when did you have your most recent prostate exam? ____ (year)**

48. Have you ever had a blood test to look for cancer of the prostate (PSA)?

1. ____ NO
2. ____ YES → **If YES, When did you have your most recent blood test to look for prostate cancer?**

_____ (year)

QUESTIONS FOR WOMEN ONLY

49. Do you perform breast self-exam (BSE) once a month?

1. ____ NO
2. ____ YES

50. Have you ever had a mammogram?

1. ____ NO
2. ____ YES → **If YES, have you had a mammogram within the last year?**
   a. _____ no
   b. _____ yes, month _____ year _____

51. Have you had a hysterectomy (surgical removal of the uterus)?

1. ____ YES (go to question 52)
2. ____ NO → **If NO, have you ever had a Pap smear/pelvic examination?**
   a. _____ no (go to question 52)
   b. _____ yes, month _____ year _____

52. Have you ever had a bone density test or any test for osteoporosis?

1. ____ NO
2. ____ YES → **If YES, have you had a bone density test within the last 2 years?**
    a. _____ no
    b. _____ yes, month _____ year _____

53. Do you have any other health problems that you would like your doctor to know about before your visit?