CARE VISIT FORM - Please complete this form prior to your appointment

Name: _____ Date of Birth: ___/___/ 19___

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

Physician/Specialist name	***TYPE***	***Condition / Disease treated for***	***Visit frequency***
Example: Dr John Smith	Cardiology	High blood pressure	2 times a year

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	***Month / Yr***	***Operation / Hospitalization / Injury***	***Month / Yr***

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

♦ Medications, Vitamins and Herbal Supplements ♦

Please bring your medications in the bottle with you

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				

Brother(s):				
Sister(s):				

♦ Disease Prevention and Health Maintenance ♦ *Please list below the most recent dates of your vaccines and health screening tests*					
	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia 13 vaccine		Pap Smear		Heart Catheterization	
Pneumonia 23 vaccine		Colonoscopy		Endoscopy (EGD)	
Tetanus Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Abdominal Aneurysm Screen	
Other		Chest X-Ray		Diabetic foot exam	
		Advanced Directive or Living Will		Other	

Have you had a fall in the last year?_____

If yes, have you had more than one fall in the last year?_____

Have you had one or more injuries related to falls this year? _____

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