Established Patient - Form & Visit Day Instructions

The purpose of this form is to update us on any changes in your health and history.
Please complete this form in advance of your physical appointment. Be sure to bring it with you. These forms are confidential. They are used to evaluate your health and risk factors for disease.

On the Day of your Appointment:

- Please do not wear any lotions or oils.
- If you have a morning appointment, please do not eat before your appointment so that we can check fasting blood cholesterol and sugar at your visit. You **should** take all your medicine (except for your oral diabetic medicine if you are on any) with a glass of water or black coffee. Do not eat for 14 hours if you are on medicine for cholesterol.
- If you have an afternoon appointment, please do not eat for 2 hours before your appointment but do take all your medicine or plan to have a fasting blood testing appointment earlier on your day or on a separate day.
- If you have diabetes and take insulin, you may eat your morning meal and take your insulin on the day of the visit unless otherwise advised by your doctor.

Name_____ Appointment Date_____
Age____ Spare time activities_____Occupation_____

What **questions** or **problems** do you wish to discuss with the doctor during your evaluation?

_____

_____

_____

Circle if you're allergic to: Latex, Contrast Dye, Shellfish, Iodine, Anesthesia_____or none of those.
Please **RE-LIST** all **allergies** to medications:

Drug_____Reaction_____ Drug_____Reaction_____

_____ _____

_____ _____

Please **RE-LIST** for us **ALL** of your regular **medications including birth control, over-the-counter medicines, vitamins and health food store products**. **Please include dosage (strength as listed on the medication bottle) and number of times per day**.

1_____ 7_____
2_____ 8 _____
3_____ 9_____
4_____ 10 _____
5_____ 11 _____
6_____ 12_____

Last Screening tests dates and name of provider or hospital:
Colonoscopy_____
Men Only - PSA (prostate cancer blood test) _____
Women Only - Pap Test _____ Mammogram _____
DXA bone density scan_____

PLEASE BRING ALL FORMS WITH YOU ON THE DAY OF YOUR VISIT

NINTH STREET INTERNAL MEDICINE

Name_____
Last **First** **MI**

Address_____

City_____ **State**_____ **Zip**_____

Telephone: Home_____ **Cell**_____ **Work**_____

Your Primary Doctor at NSIM_____ **Referred by**_____

Date of Birth_____ **Sex**_____ **Marital Status**_____
M / F/Trans **M /S /D /W /Other**

Do you have a Hearing Impairment Y/ N Vision Impairment Y/N

Race _____ **Primary Language**_____ **Ethnicity**_____

Email Address_____
*** May we contact you by Email** ☐ **Yes** ☐ **No**

Emergency Contact(s)
1) Name:_____ **Relationship**_____

Telephone Home:_____ **Work:**_____ **Cell**_____

2) Name:_____ **Relationship**_____

Telephone Home:_____ **Work:**_____ **Cell**_____

PRIMARY INSURANCE
Insurance Co:_____ **Subscriber**_____

Subscribers Date of Birth_____ **Relationship to insured**_____

SECONDARY INSURANCE
Insurance Co:_____ **Subscriber**_____

Subscribers Date of Birth_____ **Relationship to insured**_____

PRESCRIPTION PLAN_____

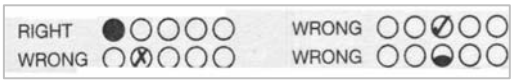
1. **LOCAL Pharmacy Name**_____ **Phone**_____
2. **MAIL ORDER Pharmacy Name**_____ **Phone**_____

Do you have an Advance Directive? Y/N

Please bring ALL Insurance Cards to the front desk so that we can scan them into your record

Name: _____ Date: _____

Do you have any of the following:



Fatigue	O Yes	O No
Falls	O Yes	O No
Rash	O Yes	O No
Nasal congestion	O Yes	O No
Dizziness	O Yes	O No
Sore Throat	O Yes	O No
Post-nasal Drip	O Yes	O No
Hearing Loss	O Yes	O No
Headache	O Yes	O No
Tingling/Numbness	O Yes	O No
Sleep Problems	O Yes	O No
Memory Loss	O Yes	O No
Visual Changes	O Yes	O No
Chest Pain	O Yes	O No
Shortness of Breath	O Yes	O No
Leg swelling	O Yes	O No
Palpitations	O Yes	O No
Heartburn	O Yes	O No
Indigestion	O Yes	O No
Nausea	O Yes	O No
Abdominal Pain	O Yes	O No
Diarrhea	O Yes	O No
Constipation	O Yes	O No
Blood in Stool	O Yes	O No
Change in Bowel Habits	O Yes	O No
Hemorrhoids	O Yes	O No
Clotting problems	O Yes	O No
Bleeding problems	O Yes	O No
Urinary Frequency	O Yes	O No
Urinary Urgency	O Yes	O No
Urinary Incontinence	O Yes	O No
Blood in Urine	O Yes	O No
Kidney Stones	O Yes	O No
Back Pain	O Yes	O No
Joint Pain	O Yes	O No
Loss of height	O Yes	O No

Patient Comments Below:

Name: _____ Date: _____

Marital Status: O single O married O partnered O divorced/separated O widowed

Number of people in household: O 1 O 2 O 3 O 4 O 5 O 6 or more

Highest education level: O high school O college O graduate school

How often do you drink beer, wine or alcohol? O monthly or less O 2-4 times a month O 2-3 times a week O 4 or more times a week

How often do you have more than 6 such drinks on one occasion? O never O less than monthly O monthly O once a week or more

Smoking: O never O former O occasional O 1/4 pack a day O 1/2 pack a day O 1 pack a day or more

Other tobacco use? O Yes O No

Recreational drug use? O Yes O No

Caffeine intake(coffee, tea, soda): O never O occasional O 1-2 cups a day O 3 or more a day

Regular seatbelt use? O Yes O No

Guns in the house? O Yes O No

Home smoke detector use? O Yes O No

Exercise: O never O occasional O 1-2 days a week O 3-5 days a week

Significant weight gain in past year? O 5-10 lbs O 10-20 lbs O 20 lbs or more

Significant weight loss in the past year? O 5-10 lbs O 10-20 lbs O 20 lbs or more

Any questions about sex you would like to discuss with your doctor? O Yes O No

Regular eye care? O Yes O No

Regular dental care? O Yes O No

Special diet? O Yes O No

Currently in a sexual relationship? O Yes O No

Have you ever been hit, kicked or hurt by someone? O Yes O No

Does a partner from a current or past relationship make you feel unsafe? O Yes O No

What are you currently using or what would you use for sexually transmitted disease prevention? O N/A O condoms O female condoms O other barrier methods

What are you or your partner using for birth control/contraception? O N/A O condoms O condoms plus other O diaphragm O IUD O tubal ligation or vasectomy O OCP(the pill) O nuvaring O depo

Number of pregnancies: O 0 O 1 O 2 O 3 O 4 O 5 or more

Number of live births: O 0 O 1 O 2 O 3 O 4 O 5 or more

Pregnancy complications: O Yes O No

How is your life in general? O disastrous O fair O good O very good O excellent

Do you have Anxiety? O Yes O No

In the last 2 weeks, have you been down or depressed? O Yes O No

In the last 2 weeks, have you had little interest or pleasure in doing things you normally enjoy? O Yes O No

BAI®

NAME _____ **DATE** _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant, but I could stand it.	SEVERELY I could barely stand it.
1. Numbness or tingling.				
2. Feeling hot.				
3. Wobbliness in legs.				
4. Unable to relax.				
5. Fear of the worst happening.				
6. Dizzy or lightheaded.				
7. Heart pounding or racing.				
8. Unsteady.				
9. Terrified.				
10. Nervous.				
11. Feelings of choking.				
12. Hands trembling.				
13. Shaky.				
14. Fear of losing control.				
15. Difficulty breathing.				
16. Fear of dying.				
17. Scared.				
18. Indigestion or discomfort in abdomen.				
19. Faint.				
20. Face flushed.				
21. Sweating (not due to heat).				

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The CAGE and CAGE-AID Questionnaires

Item	Text
1.	Have you ever felt you ought to cut down on your drinking *or drug use*?
2.	Have people annoyed you by criticizing your drinking *or drug use*?
3.	Have you ever felt bad or guilty about your drinking *or drug use*?
4.	Have you ever had a drink *or used drugs* first thing in the morning to steady your nerves or to get rid of a hangover?

Note. The plain text shows the CAGE questions. The italicized text was added to produce the CAGE-AID. For this study, the CAGE-AID was preceded by the following instruction: "When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed."

The CAGE and CAGE-AID Questions

The original CAGE questions appear in plain type. The CAGE questions Adapted to Include Drugs (CAGE-AID) are the original CAGE questions modified by the *italicized text.*

The CAGE or CAGE-AID should be preceded by these two questions:

1. Do you drink alcohol?
2. Have you ever experimented with drugs?

If the patient has experimented with drugs, ask the CAGE-AID questions. If the patient only drinks alcohol, ask the CAGE questions.

CAGE and CAGE-AID Questions

1. In the last three months, have you felt you should cut down or stop drinking or *using drugs?*
   Yes No
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs?*

   Yes No
3. In the last three months, have you felt guilty or bad about how much you drink *or use drugs*?

   Yes No
4. In the last three months, have you been waking up wanting to have an alcoholic drink or *use drugs*?

   Yes No

Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.

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MDVIP
211 S. 9th Street Suite 401
Philadelphia PA 19107
Ph: 215-440-8681 Fax:215-440-9953

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: **Date:**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or feeling that you are a failure or that you have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things such as reading or watching TV	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better dead or that you want to hurt yourself in some way	☐	☐	☐	☐

RATE YOUR PLATE

Think about the way you usually eat. For each food topic, put a check mark in column A, B or C.

TOPIC	A	B	C
1. **GRAINS** *1 Serving* = 1 slice bread or tortilla; ½ bagel, roll, English muffin or pita; ½ cup cooked rice or pasta; 1 cup cereal	❑ **Usually eat:** less than 4 servings of grain products a day	❑ **Usually eat:** 4-5 servings of grain products a day	❑ **Usually eat:** 6 or more servings of grain products a day
2. **WHOLE GRAINS**	❑ **Usually eat:** white breads, white rice, low fiber cereals like corn flakes, rice krispies, etc.	❑ **Sometimes eat:** less than 4 servings of grain products a day	❑ **Usually eat:** whole grain breads, brown rice, whole grain cereals like oatmeal, bran cereals, Wheaties™, etc.
3. **FRUITS & VEGETABLES** *1 Serving* = ½ cup cooked or 1 med. fruit or 1 cup leafy raw vegetables or 4 oz. 100% fruit or veg. Juice	❑ **Usually eat:** 1 serving or less a day	❑ **Usually eat:** 2-4 servings a day	❑ **Usually eat:** 5 or more servings a day
4. **DAIRY FOODS** *1 Serving* = 1 cup milk or yogurt; 1 ½ -2 ounces cheese	❑ **Rarely eat or drink:** 2 or more servings of milk, yogurt, or cheese a day	❑ **Sometimes eat or drink:** 2 or more servings of milk, yogurt, or cheese a day	❑ **Usually eat or drink:** 2 or more servings of milk, yogurt, or cheese a day
5. **MEAT, CHICKEN, TURKEY OR FISH** *1 Serving* = 3 oz. (the size of a deck of cards) or 1 regular hamburger, 1 chicken breast or leg, or 1 pork chop	❑ **Usually eat:** more than 6 ounces of meat, chicken, turkey or fish per day	❑ **Sometimes eat:** more than 6 ounces of meat, chicken, turkey or fish per day	❑ **Rarely/never eat:** more than 6 ounces of meat, chicken, turkey or fish per day
6. **EATING OUT** in restaurants or getting take-out food	❑ **Usually eat out or get take-out food:** twice a week or more	❑ **Usually eat out or get take-out food:** once a week or more	❑ **Usually eat out or get take-out food:** less than once a week OR usually eat low-fat restaurant meals
7. **RED MEAT** (includes beef, hamburger, pork, lamb or veal)	❑ **Usually eat:** three times a week or more	❑ **Usually eat:** twice a week	❑ **Usually eat:** once a week or less
8. **RED MEAT CHOICES** (includes beef, hamburger, pork, lamb or veal)	❑ **Usually eat:** high-fat cuts, such as ribs, brisket, T-bone steak, prime rib, sausage, regular or lean ground beef	❑ **Sometimes eat:** high-fat cuts, such as ribs, brisket, T-bone steak, prime rib, sausage, regular or lean ground beef	❑ **Usually eat:** lean beef such as round, loin, flank, lean pork and lamb such as loin and leg, veal, ground turkey breast OR rarely/never eat meat
9. **COLD CUTS, HOT DOGS, BREAKFAST MEATS**	❑ **Usually eat:** salami, bologna, other cold cuts, hot dogs, bacon, sausage	❑ **Sometimes eat:** salami, bologna, other cold cuts, hot dogs, bacon, sausage	❑ **Usually eat:** roast beef, turkey breast, ham or low-fat cold cuts, low-fat hot dogs, low fat bacon/sausage

10. **CHICKEN, TURKEY, ETC**	❑ **Usually eat:** chicken, turkey, and other poultry **with** skin	❑ **Sometimes eat:** chicken, turkey, and other poultry **with** skin	❑ **Usually eat:** chicken, turkey, and other poultry **without** skin
11. **CHICKEN AND FISH CHOICES**	❑ **Usually eat:** fried chicken and/or fried fish and shellfish	❑ **Sometimes eat:** fried chicken and/or fried fish and shellfish	❑ **Usually eat:** chicken and fish that is baked, broiled, grilled, poached, roasted, etc.

TOPIC	A	B	C
12. **MEATLESS MAIN DISHES** such as all-bean chili, bean burrito, lentil soup, meatless spaghetti sauce	❑ **Rarely eat:** meatless main dishes	❑ **Usually eat:** meatless main dishes less than twice a week	❑ **Usually eat:** meatless main dishes twice a week or more
13. **MILK**	❑ **Usually eat:** whole milk or cream	❑ **Usually eat:** 2% reduced-fat milk	❑ **Usually eat:** 1% low-fat or skim milk
14. **CHEESE** includes cheese on pizza, sandwiches, snacks and in mixed dishes	❑ **Usually eat:** regular cheese such as cheddar, Swiss and American	❑ **Sometimes eat:** regular cheese such as cheddar, Swiss and American	❑ **Usually eat:** reduced-fat or part-skim cheese OR rarely eat cheese
15. **FROZEN DESSERTS** **ice cream, etc.**	❑ **Usually eat:** regular ice cream, ice cream bars/sandwiches	❑ **Sometimes eat:** regular ice cream, ice cream bars/sandwiches	❑ **Usually eat:** sherbet, sorbet, low-fat frozen yogurt or ice cream OR rarely eat frozen desserts
16. **COOKING METHOD**	❑ **Usually add:** oil, butter or margarine to the pan	❑ **Sometimes add:** oil, butter or margarine to the pan	❑ **Usually eat:** broil, bake, or steam without fats or oils or use cooking sprays (Pam)
17. **FRIED FOODS** such as french fries, egg rolls, onion rings, etc.	❑ **Usually eat:** fried foods	❑ **Sometimes eat:** fried foods	❑ **Rarely/Never eat:** fried foods
18. **SPREADS** added at the table	❑ **Usually put:** butter or stick margarine on bread, potatoes, vegetables, etc.	❑ **Usually put:** liquid or tub margarine on bread, potatoes, vegetables, etc.	❑ **Usually put:** "light" tub margarine on bread, potatoes, vegetables, etc. OR eat them plain
19. **SALAD DRESSING & MAYONNAISE**	❑ **Usually use:** regular salad dressing or mayonnaise	❑ **Sometimes use:** regular salad dressing or mayonnaise	❑ **Usually use:** light or fat-free salad dressing and mayonnaise
20. **SNACKS**	❑ **Usually eat:** regular chips, crackers and nuts	❑ **Sometimes eat:** regular chips, crackers and nuts	❑ **Usually eat:** fruit, pretzels, low-fat crackers or baked chips
21. **DESSERTS AND SWEETS**	❑ **Usually eat:** donuts, cookies, cake, pie, pastry or chocolate	❑ **Sometimes eat:** donuts, cookies, cake, pie, pastry or chocolate	❑ **Usually eat:** fruit, angel food cake, low-fat or fat-free sweets
22. **ADDED SALT**	❑ **Usually:** add salt to food when cooking or at the table	❑ **Sometimes:** add salt to food when cooking or at the table	❑ **Rarely/Never:** add salt to food when cooking or at the table
23. **CANNED FOODS, FROZEN PACKAGED MEALS**	❑ **Usually:** choose regular canned/frozen/packaged foods	❑**Sometimes:** choose regular canned/frozen/packaged foods	❑ **Usually:** choose low sodium canned/frozen/packaged foods OR rarely eat these foods
24. **SALTY SNACKS** chips, pretzels, crackers, salted nuts	❑ **Often eat:** salty snacks	❑ **Sometimes eat:** salty snacks	❑ **Rarely/Never eat:** salty snacks
25. **DESSERTS AND SWEETS**	❑ **Usually eat:** high sugar desserts and sweets	❑ **Sometimes eat:** high sugar desserts and sweets	❑ **Usually eat:** low sugar desserts and sweets
26. **SODA, PUNCH, ETC**	❑ **Usually drink:**	❑ **Usually drink:**	❑ **Usually drink:**

Soda, pop, fruit drink, punch, Kool-Aid™, etc.	16 oz. or more of regular (non-diet) soda, punch etc. per day	8-15 oz. or more of regular (non-diet) soda, punch etc. per day	Less than 8 oz. or more of regular (non-diet) soda, punch etc. per day
27. **BEER, WINE, LIQUOR** *1 Drink* = 12 oz. beer, 5 oz. wine, one shot of hard liquor or mixed drink with 1 shot	❑ **Often drink:** more than 1-2 alcoholic drinks in a day	❑ **Sometimes drink:** more than 1-2 alcoholic drinks in a day	❑**Rarely/Never drink:** more than 1-2 alcoholic drinks in a day

SEXUAL HEALTH INVENTORY FOR MEN (SHIM)

PATIENT NAME: **TODAY'S DATE:**

PATIENT INSTRUCTIONS

Sexual health is an important part of an individual's overall physical and emotional well-being. Erectile dysfunction, also known as impotence, is one type of very common medical condition affecting sexual health. Fortunately, there are many different treatment options for erectile dysfunction. This questionnaire is designed to help you and your doctor identify if you may be experiencing erectile dysfunction. If you are, you may chose to discuss treatment options with your doctor.

Each question has several possible responses. Circle the number of the response that **best describes** your own situation. Please be sure that you select one and only one response for **each question**.

OVER THE PAST 6 MONTHS:

1. How do you rate your confidence that you could get and keep an erection?		VERY LOW	LOW	MODERATE	HIGH	VERY HIGH
		1	2	3	4	5
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	NO SEXUAL ACTIVITY	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	DID NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?	DID NOT ATTEMPT INTERCOURSE	EXTREMELY DIFFICULT	VERY DIFFICULT	DIFFICULT	SLIGHTLY DIFFICULT	NOT DIFFICULT
	0	1	2	3	4	5
5. When you attempted sexual intercourse, how often was it satisfactory for you?	DID NOT ATTEMPT INTERCOURSE	ALMOST NEVER OR NEVER	A FEW TIMES (MUCH LESS THAN HALF THE TIME)	SOMETIMES (ABOUT HALF THE TIME)	MOST TIMES (MUCH MORE THAN, HALF THE TIME)	ALMOST ALWAYS OR ALWAYS
	0	1	2	3	4	5

Add the numbers corresponding to questions 1-5. TOTAL: The Sexual Health Inventory for Men further classifies ED severity with the following breakpoints: 1-7 Severe ED 8-11 Moderate ED 12-16 Mild to Moderate ED 17-21 Mild ED