1. Since your last visit, have any other physicians diagnosed you with any new illnesses?
   No ___  Yes ___. If yes, what illness(s) has/have been diagnosed? ____________________________

2. Since your last visit, have you been prescribed any new medications or have you, yourself, begun any new medications (including vitamins, minerals, supplements, etc.)?
   No ___  Yes ___. If yes, what are these medications (including doses)

3. Since your last visit, have you visited the Emergency Department for any reason?
   No ___  Yes ___. If yes, when, where and why?

4. Since your last visit, have you received any vaccinations?
   No ___  Yes ___. Which one(s)? ____________________________

5. Have you had any tests ordered by another physician?
   No ___  Yes ___. Which ones? ____________________________

6. Have you developed any new allergies?
   No ___  Yes ___. To what? ____________________________

7. Has your family history (i.e., blood relatives) changed since your last visit? ___ Yes ___ No
   If yes, in what way (relative and diagnosis)? ____________________________

8. Do you smoke? ___ Yes ___ No.

9. Do you drink alcohol? ___ Yes ___ No. If yes, do you
   Feel you should cut down? ___ Yes ___ No
   Get annoyed at others telling you that you should cut down or quit? ___ Yes ___ No
   Feel guilty about drinking? ___ Yes ___ No
   Need an “eye opener” in the morning? ___ Yes ___ No

10. Do you have a working smoke alarm? ___ Yes ___ No.

11. If you have gas heat, do you have a carbon monoxide detector? ___ Yes ___ No

12. Do you wear your seat belt at all times? ___ Yes ___ No.
13. Are you troubled by any of the following?
   ___ Marital problems
   ___ Recent separation or divorce
   ___ Death of a family member or close friend
   ___ Unemployment
   ___ Spiritual problems

14. Review of systems - please check any symptoms that you currently are experiencing
   A. Skin
      ___ Rash
      ___ Hives
      ___ Dry skin
      ___ New skin growths
      ___ Yellowing of the skin
      ___ A sore that does not heal
      ___ Night sweats
      ___ Mole(s) that have changed
   B. Eyes
      ___ Cloudy vision
      ___ Eye pain
      ___ Dry or scratchy eyes
      ___ Seeing spots or floaters
      ___ Double vision
      ___ Yellowing of the eyes
   C. Ears, nose and throat
      ___ Hearing loss
      ___ Ringing in ears
      ___ Nose bleeds
      ___ Hoarseness
      ___ Mouth ulcers
      ___ Ear pain
      ___ Drainage from the ears
      ___ Sinus problems
      ___ Loss of sense of smell
      ___ Problems swallowing
      ___ Sore throat
      ___ Post nasal drip
      ___ Snoring
      ___ Tooth or gum pain
   D. Lungs
      ___ Wheezing
      ___ Coughing blood
      ___ Coughing up phlegm
      ___ Having to use multiple pillows to help you breath
      ___ Pain on breathing
      ___ Chronic cough
      ___ Shortness of breath
      ___ Having to use multiple pillows to help you breath
   E. Heart
      ___ Chest pain or tightness
      ___ Dizziness
      ___ Leg cramps while walking
      ___ Getting up at night short of breath
      ___ Getting up at night to urinate
      ___ Rapid heart beat
      ___ Irregular heart beat
      ___ Swollen ankles
      ___ Fainting
      ___ Feeling of not completely emptying
   F. Stomach and intestines
      ___ Heartburn/indigestion
      ___ Constipation
      ___ Black, tarry stools
      ___ Frequent upset stomach or vomiting
      ___ Burning abdominal pain between meals or which awakens you at night
      ___ Trouble swallowing
      ___ Abdominal pain
      ___ Diarrhea
      ___ Excessive gas
      ___ Increased hunger
      ___ Weight loss in the last six months
      ___ Weight gain in the last six months
      ___ Change in bowel habits or caliber of the stool
      ___ Blood in bowel movements or on toilet tissue
   G. Kidney and bladder
      ___ Burning after urination
      ___ Dribbling after urination
      ___ Trouble starting urination
      ___ Loss of control of the urine
      ___ Blood in the urine
      ___ Increased thirst
      ___ Feeling of not completely emptying
H. Muscles, bones and joints
   __ Joint pain
   __ Back or neck pain
   __ Locking of a joint
   __ Joint stiffness
   __ Bone pain
   __ Red or swollen joints
   __ Muscle weakness

I. Nervous system
   __ Headaches
   __ Weakness in an arm or leg
   __ Anxiety
   __ Numbness of the face, arm or leg
   __ Loss of eyesight
   __ Dizzy
   __ Problems with balance
   __ Change or loss of speech
   __ Nervousness
   __ Depression

J. Men Only
   __ Discharge from the penis
   __ Problems getting or keeping an erection
   __ Loss of sexual desire
   __ Pain during sex
   __ Pain or swelling in the testicles
   __ Lump in a testicle

K. Women Only
   __ Lump in a breast
   __ Abnormal vaginal bleeding
   __ Irregular periods
   __ Cessation of periods
   __ Discharge from the vagina
   __ Pain during sex
   __ Leaking of urine when coughing, sneezing, laughing, etc
   __ Do you examine your breasts regularly? ___ Yes ___ No

When was your last menstrual period? ________________________________

15. Please list all of your medications and their dosages -

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

16. Is there anything that you wish to discuss today, at this visit? ___ Yes ___ No

Specifically, what? ________________________________________________

_________________________________________________________________
_________________________________________________________________

Thank you very much.
LVPG Internal Medicine
### PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**  
*Use “✓” to indicate your answer*

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. 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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**FOR OFFICE CODING**  

\[ 0 + \underline{+} + \underline{+} + \underline{+} \]  

\[ = \text{Total Score: } \underline{+} \]

---

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D</strong></td>
<td><strong>D</strong></td>
<td><strong>D</strong></td>
<td><strong>D</strong></td>
</tr>
</tbody>
</table>

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