Providence

Review of Systems/Medical History Update

Patient Name_____ Date of Birth_____
Date_____ Chart Number_____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING:

General

Good general health lately	no	yes
Recent weight change	no	yes
Fever	no	yes
Fatigue	no	yes

Eyes and vision

Eye disease or injury	no	yes
Blurred or double vision	no	yes
Glaucoma	no	yes

Ears, nose, throat and mouth

Hearing loss	no	yes
Ringing in the ears	no	yes
Earaches	no	yes
Sinus problems	no	yes
Mouth sores	no	yes
Dental or chewing problems	no	yes
Dentures	no	yes

Heart trouble

Heart trouble	no	yes
Chest pains	no	yes
Sudden heartbeat changes	no	yes
Swelling of feet, ankles, hands	no	yes

Breathing trouble

Frequent coughing	no	yes
Spitting up blood	no	yes
Shortness of breath	no	yes
Asthma or wheezing	no	yes

Stomach trouble

Loss of appetite	no	yes
Change in bowel movements	no	yes
Nausea or vomiting	no	yes
Stomach pain	no	yes
Gastric Bypass or Lap Band	no	yes

Joint trouble

Cold hands/feet	no	yes
Difficulty walking	no	yes
Muscle pain or cramps	no	yes

Neurologic trouble

Frequent or recurrent headaches	no	yes
Light headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness or tingling sensations	no	yes
Tremors or shaking	no	yes
Involuntary movements	no	yes
Stroke	no	yes
Head injury	no	yes
Balance problems	no	yes

Hormone trouble

Thyroid disease	no	yes
Diabetes	no	yes
Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
Change in hat or glove size	no	yes
Change in skin color	no	yes
Change in hair or nails	no	yes

Bleeding trouble

Slow to heal after cuts	no	yes
Easily bruising or bleeding	no	yes
Anemia	no	yes

Urination trouble

Frequent urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes

ACTIVITY: (CHECK ONE OR MORE BOXES)

□ Occasional vigorous activity.
□ Regular vigorous exercise.

WOMEN:

Last menstrual period?	_____	
Any menstrual problems?	Yes_____	No_____
Number of pregnancies	_____	
Difficult pregnancy?	Yes_____	No_____
Miscarriages?	_____	
Birth control method (if any)?	_____	
Hysterectomy?	Yes_____	No_____
Breast pain/lump/discharge?	Yes_____	No_____
Last mammogram?	_____	

MEN:

Prostate problems?	Yes_____	No_____
Erectile problems?	Yes_____	No_____
Vasectomy?	Yes_____	No_____
Hormone Irregularities?	Yes_____	No_____

Patient/Guardian Signature_____Date_____

Reviewed By_____Date_____

Revised 02/13

Providence Medical Group Mat-Su Behavioral Health

Patient Name_____ Date of Birth_____
Date_____ Chart Number_____

CARROLL-DAVIDSON GENERALIZED ANXIETY DISORDER SCREEN

During the past six months:	Yes	No
1. Most days I feel very nervous.		
2. Most days I worry about lots of things.		
3. Most days I cannot stop worrying.		
4. Most days my worry is hard to control.		
5. I feel restless, keyed up or on edge.		
6. I get tired easily.		
7. I have trouble concentrating.		
8. I am easily annoyed or irritated.		
9. My muscles are tense and tight.		
10. I have trouble sleeping.		
11. Did the things noted above affect your daily life (home life, work, or leisure) or cause distress?		
12. Were the things you noted above bad enough that you thought about getting help for them?		

MODIFIED SPRINT (SPRINT-4) PTSD SCREEN

Have you ever experienced or witnessed a traumatic event, which involved loss of life, serious injury or threat of either: If yes, during the past week:	Yes	No
1. Have you been bothered by unwanted memories, nightmares, or reminders of this event?		
2. Have you been making an effort to avoid thinking or talking about this event, or doing things which remind you of what happened?		
3. Have you lost enjoyment for things, kept your distance from people, or found it difficult to experience feelings?		
4. Have you been bothered by poor sleep, poor concentration, jumpiness, irritability, or feeling watchful around you?		

Providence

Providence Medical Group Mat-Su Behavioral Health

Patient Name_____ Date of Birth_____
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THE HANDS DEPRESSION SCREENING TOOL
(The Harvard Department of Psychiatry National Depression Screening Day Scale)

During the past two weeks, how often have you:	None or little of the time	Some of the time	Most of the time	All of the time
1. Been feeling low in energy, slowed down?				
2. Been blaming yourself for things?				
3. Had poor appetite?				
4. Had difficulty falling asleep, staying asleep?				
5. Been feeling hopeless about the future?				
6. Been feeling blue?				
7. Been feeling no interest in things?				
8. Had feelings of worthlessness?				
9. Thought about or wanted to commit suicide?				
10. Had difficulty concentrating or making decisions?				

THE MOOD DISORDER QUESTIONNAIRE	Yes	No
1. Has there ever been a period of time when you were not your usual self and…		
….felt so good or so hyper that other people thought you were not your normal self or were so hyper that you got into trouble?		
…..were so irritable that you shouted at people or started fights or arguments?		
…..felt much more self-confident than usual?		
…..got much less sleep than usual and found you didn't really miss it?		
…..were much more talkative or spoke much faster than usual?		
…..thoughts raced through your head or you couldn't slow your mind down?		
…..were so easily distracted by things around you that you had trouble concentrating or staying on track?		
…..had much more energy than usual?		
…..were much more active or did many more things than usual?		
…..were much more social/outgoing, for example, you telephoned friends in the middle of the night?		
…..were much more interested in sex than usual?		
…..did things that were unusual for you or that others thought were excessive, foolish or risky?		
…..spending money got you or your family into trouble?		
2. If "YES" to more than one of the above, have they occurred during the same period of time?		
3. How much of a problem did any of these causes (missing work, family, money or legal trouble; getting into arguments or fights)? Please rate (✓) severity of problem: ☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem		