CPE
Patient Label Here

Welcome to Providence Medical Group
Gateway Family Medicine

Name: _____ Date of Birth: _____ Today's Date: _____
Preferred Name & Pronoun: _____
Who is your emergency contact person (name and phone number)? _____

Your health is important to us. This visit is a preventive care visit, where we focus on screenings, lifestyle counseling, and prevention of disease. If there are specific problems that you would like addressed we will most likely need to make a future appointment.

What are your Health Goals? _____

Do you need any medications **refilled, referrals, forms completed, or a letter for work** today? ☐ Yes ☐ No

Symptom Checklist: *Please check any symptom that you've had in past **two weeks, and that you continue to have:***

General: ☐Fatigue ☐Fevers ☐Unwanted weight changes ☐Always very thirsty ☐Always feeling too cold or hot

Eyes: ☐Blurry vision ☐Eye pain

Hearing: ☐Hearing loss ☐Ear pain

Lungs: ☐Shortness of breath ☐Cough ☐Snoring

Heart: ☐Chest pain or pressure ☐Rapid heartbeat

Gastrointestinal: ☐Abdominal pain ☐Trouble swallowing ☐Vomiting ☐Bloody or black stools

Urinary: ☐Blood in urine ☐Loss of bladder control ☐Painful urination ☐Frequent or urgent urination

Blood: ☐Abnormal bleeding ☐Easy bruising

Nervous System: ☐Seizures ☐Passing out ☐Dizzy ☐Tremor ☐Problems moving ☐Numbness ☐Trouble walking ☐Headache

Immune System: ☐Uncontrolled allergies ☐Swollen lymph nodes ☐Frequent infections

Musculoskeletal: ☐Back or neck pain ☐Joint pain

Mental health: ☐Depression ☐Anxiety ☐Memory problems ☐Trouble sleeping ☐Suicidal thinking

Skin: ☐Changing skin moles ☐Rash

If applicable: ☐Breast lumps ☐Pelvic pain ☐Excessive bleeding ☐Testicular pain or lumps ☐ Other issues

PREVENTIVE HEALTH

If applicable/if known:

1. Last menstrual period - Date: _____
2. Are you currently breast feeding? ☐ Yes ☐ No
3. When was last pap smear (if done outside of Providence)? _____
4. When was last mammogram (if done outside of Providence)? _____
5. When was last colonoscopy (if done outside of Providence)? _____

HEALTHCARE UPDATE

Any **new Medications** or medication changes since your last visit? ☐ No ☐ Yes, please list the changes:

1. _____ 3. _____
2. _____ 4. _____

Any **new Allergies** to medications? ☐ No ☐ Yes: _____

Any **new Medical Conditions**? ☐ No ☐ Yes: _____

Did you have any **recent Surgeries**? ☐ No ☐ Yes: _____

Changes in your **Family's** health? ☐ No ☐ Yes: _____

Relationship changes (marital status, etc.) ☐ No ☐ Yes: _____

SOCIAL HISTORY UPDATE

Marital Status (if applicable): _____ Occupation: _____ Hobbies: _____

Are you sexually active? ☐ Yes ☐ No
If yes:

Partners are (e.g., male, female, nonbinary, etc): _____
Are you interested in testing for sexually transmitted infection? ☐ Yes ☐ No
Do you or your partner use birth control, and if so, what do you use? _____
If no birth control, why not? ☐ Trying to get pregnant ☐ Partner(s) same sex ☐ Other

Have you ever been in a physically or verbally abusive relationship? ☐ Yes ☐ No
Are you currently in a physically or verbally abusive relationship? ☐ Yes ☐ No

Do you use **tobacco** products? ☐ Yes ☐ No ☐ Quit Date: _____ ☐ Never used tobacco
If Yes: How many packs/cans per day?_____ How many years?____ Are you interested in quitting? ☐ Yes ☐ No

How many times a week do you exercise? _____ What type of exercise do you do? _____

We ask all our adult patients about substance use and mood because these factors can affect your health. Please ask your doctor if you have any questions. Your answers on this form will remain confidential.

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

Drugs: Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	○	○

Mood:

	Not At All	Several Days	More Than One-Half The Days	Nearly Every Day
During the past two weeks, have you been bothered by little interest or pleasure in doing things?	○	○	○	○
During the past two weeks, have you been bothered by feeling down, depressed, or hopeless?	○	○	○	○

Having access to food, transportation, and other basic supports affects a person's health. The questions below focus on these supports. Based on your responses, we can connect you with needed services. We are asking all of our patients to answer these questions. You are not required to complete this form.

1. Within the past 12 months, you worried that your food would run out before you got money to buy more.
- ☐ **Never true**
- ☐ **Sometimes true**
- ☐ **Often true**

2. Within the past 12 months the food you bought just didn't last and you didn't have money to get more.
- ☐ **Never true**
- ☐ **Sometimes true**
- ☐ **Often true**

3. What is your living situation today?
- ☐ **I have a steady place to live**
- ☐ **I have a place to live today, but I am worried about losing it in the future**
- ☐ **I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station or in a park)**

4. In the past 12 months, has the electric, gas, oil or water company threatened to shut off services in your home?
- ☐ **Yes**
- ☐ **No**
- ☐ **Already shut off**

5. In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?
- ☐ **Yes**
- ☐ **No**

6. In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?
- ☐ **Yes**
- ☐ **No**

Please let us know if you would like assistance by selecting as many of the boxes below: