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

Providence Medical Group Mat-Su Behavioral Health

Patient Name_____ Date of Birth_____
Date_____ Chart Number_____

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