

<b>Personal Safety</b>	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### Family Health History

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Mother</b>				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M		<b>Grandmother</b>		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		<b>Grandfather</b>		
	<input type="checkbox"/> F		<i>Maternal</i>		
<input type="checkbox"/> M		<b>Grandmother</b>			
<input type="checkbox"/> F		<i>Paternal</i>			
<input type="checkbox"/> M		<b>Grandfather</b>			
<input type="checkbox"/> F		<i>Paternal</i>			

### Mental Health

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature of patient (or parent/guardian if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date