RESET FORM

Name:

Date of planned visit:

Reason for your visit:

Establish Primary Care

Annual Physical Exam

Other Concern:

Who was kind enough to refer you?

Please provide a current list of your healthcare professionals:

Provider Name	Specialty	Condition being treated

Please provide your pharmacy information:

Pharmacy Name	City	Phone #	Zip Code

Have you been **hospitalized** in the past 30 days? ☐ Yes ☐ No

Do you have any of the following conditions?

☐ Cataracts ☐ Glaucoma ☐ Refractive Error ☐ Hearing loss ☐ Tinnitus

☐ Allergic Rhinitis ☐ Asthma ☐ COPD/Emphysema ☐ Sleep apnea

☐ Heart disease/CAD ☐ Heart failure ☐ Hypertension ☐ Atrial Fibrillation ☐ Atherosclerosis

☐ Arthritis ☐ Gout ☐ Back Pain ☐ Osteoporosis/penia

☐ High Cholesterol ☐ Thyroid disorder ☐ Diabetes (Insulin/Non-Insulin) or Metabolic Syndrome

☐ Breast Cancer ☐ Uterine Cancer ☐ Colon Cancer ☐ Prostate Cancer ☐ Lung

☐ Depression ☐ Anxiety Disorder ☐ Eating disorder

☐ Other Conditions:

What Operations have you had in the past?

☐ None ☐ Tonsillectomy/Adenoidectomy ☐ Appendix ☐ Gallbladder

☐ Hysterectomy ☐ Prostate ☐ Cosmetic procedures

☐ Other:

What Medications do you take?

Name of Medication	Dose	Frequency

Do you have any drug Allergies?

Name of Drug	Severity of Allergy	Reaction During Allergy

Do you smoke? ☐ No ☐ Yes, and I might quit ☐ Yes, but I am not ready to quit

Do you drink alcohol? ☐ Yes ☐ No

Do you use recreational or other drugs? ☐ Yes ☐ No

How much caffeine drinks do you consume daily?

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Do you have Children? ☐ Yes ☐ No

Residence: ☐ House ☐ Apartment ☐ Skilled Nursing Facility

Are you Sexually Active: ☐ Yes ☐ No

Have you ever had a sexually transmitted disease: ☐ Yes ☐ No

What is your Profession:

Family History

How old are your: Father Mother Brother(s) Sister(s)

Do any of the following conditions run in the family? And if so whom?

- ☐ Alzheimer's Disease
- ☐ Parkinson's Disease
- ☐ Migraines
- ☐ Stroke
- ☐ Sleep apnea
- ☐ Allergic Rhinitis
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Hi cholesterol
- ☐ Atrial Fibrillation
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Auto immune Disorders
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Breast Cancer
- ☐ Uterine Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ Lung Cancer
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Other

In the last four weeks, have you noted any of the following?

- ☐ Fatigue
- ☐ Weight gain or loss
- ☐ Fever
- ☐ Red eye
- ☐ Blurry vision**/visual change**
- ☐ Loss of sight
- ☐ Ear pain/**Hearing Loss**
- ☐ Sinus pain /Snoring
- ☐ Sore throat
- ☐ Runny Nose
- ☐ Post Nasal Drip
- ☐ Sneezing
- ☐ Cough
- ☐ Shortness of breath
- ☐ Stop breathing during sleep
- ☐ Chest pain/tightness
- ☐ Palpitations
- ☐ Swelling of feet
- ☐ Snoring
- ☐ Nausea or vomiting
- ☐ Episodic bloating, constipation, diarrhea
- ☐ Change in bowel habits
- ☐ Heartburn/indigestion/stomach ache
- ☐ Persistent constipation
- ☐ Black bowel movement or rectal bleeding
- ☐ Difficulty swallowing/food getting stuck
- ☐ Burning/ Pain with urination
- ☐ Difficulty starting or stopping urination
- ☐ Nighttime urinary difficulties
- ☐ Rash
- ☐ Yellow skin
- ☐ Eczema
- ☐ Blood in the urine
- ☐ Nosebleed
- ☐ Easy bruising
- ☐ Lymph enlargement
- ☐ Sexual difficulties
- ☐ Back Pain
- ☐ Foot pain
- ☐ Joint aches/swelling
- ☐ Heat/Cold Intolerance
- ☐ Thirst/Frequent Urination
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety
- ☐ Dizzy spells
- ☐ Passing our/fainting
- ☐ Tremor/shaking
- ☐ Forgetfulness
- ☐ Headaches
- ☐ Numbness
- ☐ Paralysis/weakness
- ☐ Trouble eating well
- ☐ Problem using telephone
- ☐ Difficulty driving
- ☐ Trouble with teeth/dentures
- ☐ Little interest in doing things
- ☐ Down, depressed or hopeless

Please answer yes or no to the following questions:

Activities of Daily Living / Instrumental Activities of Daily Living	YES	NO
Have you **fallen** two or more times in the past year?		
Were you injured in any falls in the past year?		
Can you drive a car, shop for groceries, without help?		
Can you prepare your own meals?		
Can you handle your own housework without help?		
Can you handle your own money without help?		
Do you need help eating, bathing, dressing or getting around your home?		
Have you been given information to help you keep track of your medications?		
Have you noticed, or has any other person had concern about your **mental status or memory**?		
Have you been given any information to help you identify hazards in your home that may hurt you?		
Do you always fasten your seatbelt when you are in a car?		
Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs, or have poor lighting?		
If you have space heaters, are they away from flammable objects?		
Do you have a fire exit plan?		
Do you have working smoke detectors and regularly change the batteries?		

During the past 4 weeks, how much have you been bothered by **emotional problems** such as feeling anxious, depressed, irritable, sad or downhearted and blue?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

During the past 4 weeks, has **your physical and emotional health** limited your social activities with family, friends, neighbors or groups?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

During the past 4 weeks, how would you **rate your general health**?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

During the past 4 weeks, how have things been going for you?

☐ Very well ☐ Pretty good ☐ Good & bad equally ☐ Pretty bad ☐ Very bad

During the past 4 weeks, how much **bodily pain** have you generally had?

☐ No Pain ☐ Very Mild Pain ☐ Mild Pain ☐ Moderate Pain ☐ Severe Pain

During the past 4 weeks, was **someone available** to help you if you needed and wanted help? *For example, if you felt nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.

☐ Yes, as much as I wanted ☐ Yes, quite a bit ☐ Yes, some ☐ Yes, a little ☐ None

Do any of these issues pose a **psychosocial stressor** (select all that apply):

☐ Home ☐ Work ☐ Social life ☐ Finances ☐ Health

Advanced Care Planning

Do you have a living will? ☐ Yes ☐ No

Do you have an advanced directive? ☐ Yes ☐ No

Do you have a durable power of attorney for healthcare? ☐ Yes ☐ No

Who is your decision maker should you not be able to medical decisions on your own?

Name	Relation	Phone Number

The answers on this form have been reviewed and discussed in detail with the patient.

Physician Signature

Date