

FOUR SEASONS FAMILY PRACTICE

DATE: _____ **D.O.B:** _____

PATIENT NAME: _____

Why are you here Today?

1.
2.
3.
Do you have: _____ Asthma _____ Diabetes _____ Heart or Vascular Disease

Marital Status: single married separated divorced widowed partner

Use of Alcohol: never rarely moderate daily

Use of Tobacco: never previously, but quit Current packs per day _____

Are you interested in smoking cessation counseling and information? Yes No

Use of drugs: never type/ frequency _____

Occupation _____

Have you had any changes in your family history? Yes No

The Joint Commission recommends we ask all patients the following questions:

	YES	NO
Have you had any falls in the past 12 months?		
In the past 2 weeks, have you felt down, depressed, or hopeless?		
In the past 2 weeks, have you had little interest or pleasure in doing things?		
Do you currently feel unsafe in your home?		
Do you have pain today? Where is your pain: On a scale 1-10, what number is your pain: What helps your pain:		

Please go to the back of this form to check off anything that relates to today's visit.