**CMG HEALTH QUESTIONAIRE**

Reason for today’s visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you’d like to work on to improve your health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have one of the following conditions, please answer:

Diabetes: Any problems with medications? 🞏 Yes 🞏 No Home glucose readings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High blood pressure: Any problems with meds? 🞏 Yes 🞏 No Home BP readings \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High cholesterol: Any problems with meds? 🞏 Yes 🞏 No

Depression: Any problems with meds? 🞏 Yes 🞏 No Any suicidal thoughts? 🞏 Yes 🞏 No

Depression screen: Over the last 2 weeks have you been bothered by little interest or pleasure in doing things, or feeling down, hopeless, or depressed? 🞏 Yes 🞏 No

Have you been to the ER, hospital, or another doctor? 🞏 Yes 🞏 No

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIFESTYLE**

Exercise: What do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can you walk a block or climb a flight of stairs without getting short of breath? 🞏 Yes 🞏 No

Smoking: How much do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you interesting in quitting? 🞏 Yes 🞏 No

Alcohol: How many drinking days do you have per week? \_\_\_\_ On average how many drinks per drinking day? \_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had more than 4 drinks in a day in the past 3 months? 🞏 Yes 🞏 No Are you or others concerned about your drinking? 🞏 Yes 🞏 No

Caffeine: How much caffeine do you consume per day? (e.g., coffee, tea, chocolate, soda) \_\_\_\_\_\_\_\_\_\_\_

Falls: Have you fallen in the past year? 🞏 Yes 🞏No Do you have problems with walking or balance?  Yes  No

Safety: Are you in a relationship where you feel unsafe or have been hurt? 🞏 Yes 🞏 No

 Do you regularly wear a seatbelt? 🞏 Yes 🞏 No

HIV testing: Would you like HIV testing? 🞏 Yes 🞏 No (If yes, please tell the nurse.) HIV testing is recommended for anyone at risk for HIV infection, including persons with a sexually transmitted disease or history of injection drug use, sex workers, sexual partners of HIV-infected persons, or persons at risk.

Birth control method (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

End-of-life care: Do you want to discuss end-of-life issues? 🞏 Yes 🞏 No

Medications: Do you have any trouble taking any of your medications? 🞏 Yes 🞏 No

Please list current medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergic: 🞏 hay fever 🞏 No Allergies Please identify what you are allergic to and what reaction

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**REVIEW OF SYSTEMS**

**Have you or a family member had any of the following?** Please check and circle self, mother, father

Constitutional symptoms: 🞏fever 🞏 weight loss 🞏 extreme fatigue **self mother father**

Eyes: 🞏 double vision 🞏 sudden loss of vision **self mother father**

Ears, nose, mouth, and throat: 🞏 sore throat 🞏 runny nose 🞏 ear pain **self mother father**

Cardiovascular: 🞏 chest pain 🞏 palpitations Respiratory: 🞏 cough 🞏 wheezing 🞏 shortness of breath

**self mother father**

Gastrointestinal: 🞏 nausea 🞏 vomiting 🞏 abdominal pain 🞏 constipation 🞏 diarrhea 🞏 blood in stools

**self mother father**

Genitourinary: 🞏 irregular menses 🞏 vaginal bleeding after menopause 🞏 frequent or painful urination 🞏 bloody urine 🞏 impotence **self mother father**

Skin: 🞏 rash 🞏 changing mole **self mother father**

Sleep: 🞏 snoring 🞏 difficulty sleeping **self mother father**

Neurological: 🞏 headache 🞏 persistent weakness or numbness on one side of the body 🞏 falling

**self mother father**

Musculoskeletal: 🞏 joint pain 🞏 muscle weakness **self mother father**

Psychiatric: 🞏 depression 🞏 anxiety 🞏 suicidal thoughts **self mother father**

Endocrine: 🞏 excessive thirst 🞏 cold or heat intolerance 🞏 breast mass **self mother father**

Hematologic: 🞏 unusual bruising or bleeding 🞏 enlarged lymph nodes **self mother father**

**Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**