NWIH
Integrated Health

Patient Medical History

Name:_____ **ID:**_____ **Date:** _____

Allergies (any known allergies to medications, food, or other): _____

_____

Immunizations Dates: Hepatitis A: _____ Hepatitis B: _____ Tetanus: _____ Pneumococcal Disease: _____

Influenza: _____ COVID: _____

Current Medications:

☐ No current medications

Medication Name	Purpose	Prescribing doctor	Dose	Frequency

Surgical History:

☐ No past surgeries

Procedure	Date

Medical Conditions:

☐ No current medical concerns

Current medical diagnoses: _____

_____

Past medical diagnoses	Date

Review of Systems:

(Check the boxes below if you have experienced these symptoms within the last 30 days)

General
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Body aches
- ☐ Cannot sleep
- ☐ Decrease in appetite
- ☐ Weakness

Integumentary
- ☐ Rash
- ☐ Hives
- ☐ Itching
- ☐ Hair loss
- ☐ Increased dryness of skin

Ears/nose/throat
- ☐ Hearing loss
- ☐ Ear infections
- ☐ Ears ringing
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Sinus problems

Respiratory
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Cough
- ☐ Coughing up blood
- ☐ Sleep apnea

Cardiovascular
- ☐ Chest pain or pressure
- ☐ Irregular or rapid heartbeat
- ☐ Leg cramps while walking
- ☐ Shortness of breath when lying flat
- ☐ Swelling feet/ankles

Gastrointestinal
- ☐ Heartburn or indigestion
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Pain
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Nausea
- ☐ Reflux

Renal/Urinary
- ☐ Difficulty urinating
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urinary incontinence

Gynecological (females only)
- ☐ Last menstrual cycle: _____
- ☐ Heavy menstrual flow
- ☐ Hot flashes
- ☐ Vaginal discharge

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Pain
- ☐ Arthritis
- ☐ Muscle pain/cramps

Neurological
- ☐ Seizures
- ☐ Speech delay
- ☐ Delayed motor skills
- ☐ Poor balance
- ☐ Confusion
- ☐ Dementia
- ☐ Dizziness
- ☐ Headaches

Endocrine
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Fatigue
- ☐ Hyperactivity

Hemato/lymphatic
- ☐ Swollen lymph nodes
- ☐ Bleeds easily
- ☐ Bruises easily

Patient Name _____ Signature _____ Date _____

Staff Name/Credentials _____ Signature _____ Date _____

Patient Health Questionnaire – 9 (PHQ-9)

Name: _____ **ID:** _____ **Date:** _____

Over the last 2 weeks, how often have you been bothered by the following?	(0) Not at all	(1) Several Days	(2) More than half the days	(3) Nearly Every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

10. If any of the problems above are checked, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

..... To be completed by staff.....

Total Score (questions 1-9):
1-4 = Minimal depression
5-9 = Mild depression
10-14 = Moderate depression
15-19 = Moderately severe depression
20-27 = Severe depression

Staff Name/Credentials Signature Date

General Anxiety Disorder 7-Item (GAD-7)

Name:_____ **ID:**_____ **Date:**_____

Over the last 2 weeks, how often have you been bothered by the following?	(0) Not at all	(1) Several Days	(2) More than half the days	(3) Nearly Every day
1. Feeling nervous, anxious, or on edge				
2. Not able to stop of control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				

8. If any of the problems above are checked, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

..... To be completed by staff.....

Total Score (questions 1-7):
0-4 = None-Minimal anxiety
5-9 = Mild anxiety
10-14 = Moderate anxiety
15-21 = Severe Anxiety

Staff Name/Credentials Signature Date

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STOP-BANG Questionnaire

Name:_____ **ID:**_____ **Date:**_____

1. **S**noring. Do you Snore Loudly? (Loud enough to be heard through closed doors)	☐ Yes	☐ No	
2. **T**ired. Do you often feel Tired, Fatigued, or Sleepy during the daytime? (Such as falling asleep during driving or talking to someone)	☐ Yes	☐ No	
3. **O**bserved. Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep?	☐ Yes	☐ No	
4. **P**ressure. Do you have high blood pressure?	☐ Yes	☐ No	
5. **B**MI. Body Mass Index more than 35 kg/m^2?	☐ Yes	☐ No	BMI:
6. **A**ge. Older than 50?	☐ Yes	☐ No	Age:
7. **N**eck size. Is your shirt collar 16 inches/40cm or larger? (Measured around Adams apple).	☐ Yes	☐ No	Neck Size:
8. **G**ender. Male?	☐ Yes	☐ No	

Results:

☐ OSA - Low Risk: Yes to 0 - 2 questions

☐ OSA - Intermediate Risk: Yes to 3 - 4 questions

☐ OSA - High Risk: Yes to 5 - 8 questions

- ☐ or Yes to 2 or more of 4 STOP questions + male gender
- ☐ or Yes to 2 or more of 4 STOP questions + BMI > 35kg/m^2
- ☐ or Yes to 2 or more of 4 STOP questions + neck circumference 16 inches/40cm

Staff Name/Credentials Signature Date

Modified from University Health Network. Chung F et al. Anesthesiology 2008; 108: 812-821; Chung F et al Br J Anaesth 2012; 108: 768-775; Chung F et al J Clin Sleep Med Sept 2014.

(1/3/2022)

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Sexually Transmitted Infection (STI) Screening Questionnaire

Name:_____ **ID:**_____ **Date:**_____

1. Do you think you could be at risk of a STI today?	☐Yes ☐No
2. Do you ever have sex with people you don't know?	☐Yes ☐No
3. Do you ever have sex with anyone who you know to be HIV positive?	☐Yes ☐No
4. Do you ever have unprotected sex (sex without using condoms)?	☐Yes ☐No
5. Do you ever inject with a needle or "works" that are not exclusively yours?	☐Yes ☐No
6. Do you ever inject with a needle or "works" that you know others have used?	☐Yes ☐No
7. Have you ever had sex in exchange for other things like money, drugs, or a place to sleep?	☐Yes ☐No
8. Are you a woman or a man who is trying to conceive a child with a partner who is HIV-positive?	☐Yes ☐No
9. Do you have any symptoms of an STI today? (Bleeding, warts, pain, itching, rash, problems with urination, abnormal discharge, sores/blisters)	☐Yes ☐No Please list: _____
10. Have you ever tested positive or been treated for an STI?	☐Yes ☐No Please list: _____
11. Would you like any more information on birth control methods?	☐Yes ☐No

Staff Name/Credentials Signature Date