NEEDS A FOLLOW UP IN:

_____

☐ **FOLLOW UP CARD**

Primary Care Follow-up Document

Patient Name: _____ Date of birth: _____

Allergies: _____ Pharmacy: _____

Medications: _____

_____

Reason for today's visit: _____

_____

HT_____ WT: _____ Temp: _____ Pulse: _____ BP: _____/_____ Resp: _____ LMP: _____O2_____

Patient to fill out the rest of this form:

Please circle any symptoms you have (if any):

General: Fatigue Fevers Chills

Endo: Weight loss Weight Gain Hair loss Increased Thirst Increased hunger Brittle nails

Eyes: Eye redness/discharge Blurry vision Double Vision

ENT: Ear Pain Hearing loss Sore throat Sinus congestion Runny nose

Resp: Cough Shortness of breath Wheezing

Cardiac: Chest pain/pressure Heart palpitations Lower extremity swelling

GI: Abdominal pain Nausea Vomiting Diarrhea Constipation Change of Appetite Heartburn

Urinary: Frequency Urgency Burning Incontinence Blood in urine

Neuro: Headaches Dizziness Lightheadedness Numbness/tingling

Muscle: Weakness Joint Pain Muscle Pain

Skin: Rash Skin lesion

Psych: Agitation Trouble sleeping Thoughts of Suicide Substance abuse

Other:

_____

_____

_____

New Patient Intake Questionnaire

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Age: _____ Legal sex (circle): Male Female

Home Address: _____

Home Phone: _____ Cell Phone: _____

Preferred Phone (circle): Home Cell May we leave a voicemail? (circle): Yes No

Email Address: _____

Occupation: _____ Employer: _____

Primary language spoken: _____ Need interpreter? (circle): Yes No

Ethnicity (circle): Non-Hispanic Hispanic or Latino Other

Relationship status: Single Married Divorced Widowed

Emergency contact name and phone: _____-

_____

Preferred pharmacy:

_____

Previous pharmacy care provider and location:

_____

If you see any specialists, please list name, location, and specialty:

_____

Medical Records Request Form

Patient Name: _____ DOB: _____

SSN: _____ Address: _____ City: _____

State: _____ Zip Code: _____ Phone: ( ) _____ Email: _____

Information Requested From

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____ Email: _____

Please Include Copies of:

☐ Laboratory Reports ☐ Exam Reports ☐ Surgical Reports ☐ Radiology/X-Ray Reports

☐ Pathology/Biopsy Reports ☐ Entire Medical Record _____

Send Information To

Name: **Quick Care-Midtown**

Address: **8 2nd St NE Watertown, SD 57201**

Phone: 605-753-9020

I, _____ *(Name),* hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed above.

_____ _____

Printed Name **Date**

_____ _____

Signature **Date**

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers. PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
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.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Patient medical history (past and current)

AIDS/HIV	Yes	No	Eczema	Yes	No	Multiple sclerosis	Yes	No
Anemia	Yes	No	Emphysema	Yes	No	Mumps	Yes	No
Anxiety	Yes	No	Epilepsy/seizures	Yes	No	Muscle disorder	Yes	No
Arrhythmia	Yes	No	Eye or ear disorder	Yes	No	Neuropathy	Yes	No
Arthritis	Yes	No	Genetic defect	Yes	No	Osteoporosis	Yes	No
Asthma	Yes	No	Gout	Yes	No	Parkinson's disease	Yes	No
Birth Defect_____	Yes	No	Hay fever or allergies	Yes	No	Phlebitis	Yes	No
Blood disorder/clot	Yes	No	Heart attack	Yes	No	Pneumonia	Yes	No
Bone/joint disorder	Yes	No	Heart disease	Yes	No	Polio	Yes	No
Bronchitis	Yes	No	Heart murmur	Yes	No	Prostate disease or enlargement	Yes	No
Cancer: _____	Yes	No	Hepatitis	Yes	No	Psoriasis	Yes	No
Chicken pox	Yes	No	Herpes	Yes	No	Rubella	Yes	No
Cirrhosis/liver disease	Yes	No	High blood pressure	Yes	No	Seizures	Yes	No
Colitis	Yes	No	Jaundice	Yes	No	Skin disease	Yes	No
Congestive heart failure	Yes	No	Kidney disease or failure	Yes	No	Sleep apnea	Yes	No
COPD	Yes	No	Kidney stones	Yes	No	Stroke or TIA	Yes	No
Crohn's disease	Yes	No	Lactose intolerance	Yes	No	Tetanus	Yes	No
Deep vein thrombosis	Yes	No	Low blood pressure	Yes	No	Thyroid disease	Yes	No
Depression	Yes	No	Lung disease	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Measles	Yes	No	Ulcer	Yes	No
Diphtheria	Yes	No	Mental illness	Yes	No	Venereal disease (STI)	Yes	No
Diverticulitis	Yes	No	Migraine headaches	Yes	No	Other: _____	Yes	No

Current Medications (please include over the counter medications and supplements):

Medication name:	Dose:	How often:

Previous Surgeries:

Type of surgery:	Year:

Previous Hospitalizations:

Reason:	Year:

Family Medical History:

Father	
Mother	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	
Brother	
Sister	
Aunt	
Uncle	

Allergies:	Reaction:

Do you smoke cigarettes or chew and if so, how much per day? _____

Do you drink alcohol and if so, how much per day? _____

Do you use recreational drugs and if so, what, and how much per day? _____

Have you ever received (or been encouraged to receive) alcohol/drug treatment? ❑ Yes ❑ No

Have you ever lived with anyone who was a problem drinker, alcoholic, or abused drugs? ❑ Yes ❑ No