FAMILY MEDICINE ASSOCIATES OF EL PASO

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PATIENT REGISTRATION (Please Print Clearly)

Patient's Name:_____ _____
(Last) (First) (MI) (Social Security Number)

Date of Birth:_____ Age:_____ **Sex**: Male - Female
Marital Status: Single - Married - Widowed - Divorced - Separated

Home Adress:_____
(Street) (City) (State) (Zip Code)

Cell Phone:(___)_____**Home Phone**:(___)_____**Referred by**:_____

Occupation:_____ Employer:_____

Work Address:

_____
(Street) (City) (State) (Zip Code)

Email:_____Preferred Physician:_____

Preferred Pharmacy:_____ **Phone**:(___)_____

How would you like to be reminded about your appointments? Phone - Email - Text

In case of emergency, please notify:

_____Relationship_____Phone:(___)_____

Spouse' Name:_____Occupation:_____
(Last) (First)

Spouses's Employer:_____Work Phone:(___)_____

Signature:_____ **Date**:_____

Review of Systems – Please check all that apply:

SKIN
- □ Rashes
- □ Itching
- □ Change in hair or nails

HEAD
- □ Headaches
- □ Head injury

EYES
- □ Glasses or contacts
- □ Change in vision
- □ Eye pain
- □ Double vision
- □ Flashing lights
- □ Glaucoma/Cataracts
- □ Last eye exam _____

EARS
- □ Change in hearing
- □ Ear pain
- □ Ear discharge
- □ Ringing
- □ Dizziness

NOSE/SINUSES
- □ Nose bleeds
- □ Nasal stuffiness
- □ Frequent colds

ALLERGIES
- □ Hives
- □ Swelling of lips or tongue
- □ Hay fever
- □ Asthma
- □ Eczema
- □ Sensitivity to drugs, food, pollens, or dander

URINARY
- □ Difficulty in urination
- □ Pain or burning on urination
- □ Frequent urination at night
- □ Urgent need to urinate
- □ Incontinence of urine
- □ Dribbling
- □Decreased urine stream
- □ Blood in urine
- □ UTI/stones/prostrate infection

MOUTH/THROAT
- □ Bleeding gums
- □ Sore tongue
- □ Sore throat
- □ Hoarseness

NECK
- □ Lumps
- □ Swollen glands
- □ Goiter
- □ Stiffness

BREAST
- □ Lumps
- □ Pain
- □ Nipple discharge
- □ BSE

RESPIRATORY/CARDIAC
- □ Shortness of breath
- □ Cough
- □ Production of phlegm/color
- □ Wheezing
- □ Coughing up blood
- □ Chest pain
- □ Fever
- □ Night sweats
- □ Swelling in hands/feet
- □ Blue finger/toes
- □ High blood pressure
- □ Skipping heart
- □ Heart murmur
- □ HX of heart medication
- □ Bronchitis/emphysema
- □ Rheumatic heart disease

PERIPHERAL/VASCULAR
- □ Leg cramps
- □ Varicose veins
- □ Clots in veins

MUSCULOSKELETAL
- □ Pain
- □ Swelling
- □ Stiffness
- □ Decreased joint motion
- □ Broken bone
- □ Serious sprains
- □ Arthritis
- □ Gout

GASTROINTESINAL
- □ Change in appetite or weight
- □ Problems swallowing
- □ Nausea
- □ Heartburn
- □ Vomiting
- □ Vomiting blood
- □ Constipation
- □ Diarrhea
- □ Change in bowel habits
- □ Abdominal pain
- □ Excessive belching
- □ Excessive flatus
- □ Yellow color of skin (jaundice/hepatitis)
- □ Food intolerance
- □ Rectal bleeding/hemorrhoids

NEUROLOGIC
- □ Headaches
- □ Seizures
- □ Loss of consciousness/fainting
- □ Paralysis
- □ Weakness
- □ Loss of muscle size
- □ Muscle spasm
- □ Tremor
- □ Involuntary movement
- □ Incoordination
- □ Numbness
- □ Feeling of "pins and needless/tingles"

HEMATOLOGIC
- □ Anemia
- □ Easy bruising/bleeding
- □ Past transfusions

ENDOCRINE
- □ Abnormal growth
- □ Increased appetite
- □ Increased thirst
- □ Increased urine production
- □ Thyroid trouble
- □ Heat/cold intolerance
- □ Excessive sweating
- □ Diabetes

PSYCHIATRIC
- □ Tension/Anxiety
- □ Memory problems
- □ Unusual problems
- □ Past treatment with Psychiatrist
- □ Change in mood/change in attitude towards family/friends
- □ Sadness/Depression

Prescription Medication List

Medication	Dosage	Frequency	How taken (oral, topical, injection, other)

COMMENTS:

Family Medicine Associates

Hearing Health Screener

1. Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?
   ☐Yes ☐No ☐Sometimes
2. Do you sometimes feel that people are mumbling or not speaking clearly?
   ☐Yes ☐No ☐Sometimes
3. Do you experience difficulty following dialog in the movie theater?
   ☐Yes ☐No ☐Sometimes
4. Do you sometimes find it difficult to understand a speaker at a public meeting or a religious service?
   ☐Yes ☐No ☐Sometimes
5. Do you find yourself asking people to speak up or repeat themselves?
   ☐Yes ☐No ☐Sometimes
6. Do you find men's voices easier to understand than women's?
   ☐Yes ☐No ☐Sometimes
7. Do you experience difficulty understanding soft or whispered speech?
   ☐Yes ☐No ☐Sometimes
8. Do you have difficulty understanding speech on the telephone?
   ☐Yes ☐No ☐Sometimes
9. Does a hearing problem cause you to feel embarrassed when meeting new people?
   ☐Yes ☐No ☐Sometimes
10. Do you feel handicapped by a hearing problem?
    ☐Yes ☐No ☐Sometimes
11. Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?
    ☐Yes ☐No ☐Sometimes
12. Do you experience ringing or noises in your ears?
    ☐Yes ☐No ☐Sometimes
13. Do you hear better with one ear than the other?
    ☐Yes ☐No ☐Sometimes
14. Have you had any significant noise exposure during work, recreation, or military service?
    ☐Yes ☐No ☐Sometimes
15. Have any of your relatives (by birth) had a hearing loss?
    ☐Yes ☐No ☐Sometimes

Total: _____

Scoring
2 points for Yes
1 point for Sometimes
0 points for No

Scores of 3 or more: May mean that you have a hearing problem.
Scores of 6 or more: Strongly suggest that a hearing check is warranted.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 figety 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	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* 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 _____

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GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than 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 is 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

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety