Self Evaluation ***Connection to Health*** **- https://assess.connectiontohealth.org**

Date	Patient Name	DOB

List other physicians you are seeing for your healthcare (Cardiologist, OB/Gyn, Orthopedist, etc)

What are your specific health concerns?

When were the last following procedures done? (enter date of last procedure)					
	Date	Where		Date	Where
Colonoscopy			**Bone Density**		
Pap Smear			**Stress Test**		
Mammogram			**Ultrasound/Neck**		
Calcium Score			**Ultrasound/Heart**		

Write in a number using a scale of 0-10 to rate yourself on the following …	**0-3** Not doing well	**4-7** Doing well, but want to improve	**8-10** Doing well
Nutrition			
Exercise			
Substance Use (Coffee, Tobacco, Alcohol, Other Drugs)			
Stress			
Sleep			
Relationships			
Purpose for your life			
Balance between work/family/spiritual life and self			

Complete the following sentences about your health	
The best thing I do about my health is…	
Do you like your life today?	
What do you look forward to doing everyday?	
The worst thing I do for my health is….	
I want to change "this" about my *health*	
I want to change "this" about my *life*	

On a scale of 1-10 how important is this change to your life?	**(not important) 0 1 2 3 4 5 6 7 8 9 10 (very important)**	
On a scale of 1-10 how in control of your life do you feel?	**(not in control) 0 1 2 3 4 5 6 7 8 9 10 (very much in control)**	

Imagine yourself 10 to 20 years older. What aspects of your health would you guess are most important?

Social History

Tell us about you:	
What is your occupation?	
Where are you employed?	
How long have you been employed there?	
What is your level of Education?	
What are your hobbies?	
Do you have pets? If yes, what type?	
Who do you live with? (spouse, children, friend, etc)	
Where do you live (home, retirement home, parents, etc)	
Spouse's name	
Spouse's health condition (excellent, good, fair, poor)	
Do you have children? If yes, how many?	
Religion/church	

Mental Health

In the last two weeks, rate how often you have been bothered by any of the following problems (check one)				
Little interest of pleasure in doing things?	Not at all ☐	Several days ☐	☐ More than half the days	Nearly every ☐ day
Feeling down or depressed or hopeless?	Not at all ☐	Several days ☐	☐ More than half the days	Nearly every ☐ day

Medical History

List Known Allergies	

List Your Prescription Medications	

List Your Non-Prescription Medications (over the counter, herbal, etc.)	

List Surgical History	Date

Immunizations (if not done here)					
	Yes or **No**	**Date**		**Yes** or **No**	**Date**
Tetanus			**Pneumonia (last one)**		
Hepatitis B			**Meningitis**		
Hepatitis A			**MMR**		
Influenza (last one)			**Tuberculosis** (positive or neg)		

Alcohol (drink = 12oz Beer, 5oz Wine, 1 ½ oz Liquor) – ***If you do not drink alcohol skip this section***					
When you drink alcohol, what kind do you drink? (Beer, Wine, Spirits, All)					
How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 y) or more drinks in a day?					
How often do you have a drink containing alcohol?	Never ☐	Monthly or less ☐	2 to 4 times a month ☐	2 to 3 times a week ☐	4 or more times a week ☐
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2 ☐	3 or 4 ☐	5 or 6 ☐	7 to 9 ☐	10 or more ☐
How often do you have 4 or more drinks on one occasion?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
How often during the last year have you found that you were unable to stop drinking one you started?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
How often during the last year have you failed to do what was normally expected of you because of drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
How often during the last year have you felt guilt or remorse after drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
How often during the last year have you been unable to remember what happened the night before because of drinking?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
Have you or someone else been injured as a result of your drinking?	No ☐	Yes, but not in the ☐ last year	Yes, during the last ☐ year		
Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?	No ☐	Yes, but not in the ☐ last year	Yes, during the last ☐ year		
Tobacco					
Have you regularly used tobacco? (Everyday, some days, former, never)					

Year started (if applicable)	
Year stopped (if applicable)	
Cigarettes - How many packs per *day*	
Cigars - How many per *week*	
Pipe Use per *week*	
Smokeless Chew - How many dips per *day*	
Are you exposed to passive (second-hand) smoke?	

Diet	
Caffeine Drinks Per *day*	
How many calories per *day* (on average)	
Do you eat at least 5 servings of fruits and/or vegetables per *day*?	
How many servings of protein per *day*?	
How many servings of dairy per *day*?	
How many servings of whole grains per *day*?	
How many fried foods per *week*?	
How many times do you eat fast-food per *week*?	
How many servings of fish do you eat per *week*?	
How many sodas do you drink per *week*? (12oz)	
How many sweets do you eat per *day*?	
Are you taking any supplements?	
What is your daily sodium intake? (<1500, <2000, <3000)	
Do you want to change your eating habits?	

Health Risks	
Do you have any reason to believe you are at risk for Hepatitis?	
Do you have any reason to believe you are at risk for HIV?	
Do you have any reason to believe you are at risk for any other STD?	

Dental Health	
Do you have 6 month dental check ups?	
How many times do you brush your teeth per day?	
How many times do you floss your teeth per day?	

Cancer Risks	
Do you do monthly self breast exams?	
Do you do monthly self testicular exams (men only)?	
Do you have excessive sun exposure?	

Safety	
Percentage of time you wear a seatbelt?	
Percentage of time you wear a helmet?	

Exercise	
Do you Regularly Exercise?	
How many days per week do you workout?	
In a week how many days do you:	
Exercise over exerting yourself?	
Exercise with high intensity?	
Exercise with moderate intensity?	

Exercise lightly?	
In a week:	
How many ***miles*** do you walk/run?	
How many ***minutes*** do you spend hiking or walking?	
How many ***hours*** do you spend playing team sports?	
How many ***hours*** do you spend cross-country skiing?	
How many ***days*** do you down hill ski?	
How many ***days*** do you do weight lifting?	
How many ***days*** do you spend golfing or gardening?	
What other exercises do you do?	
How much time in a week do you spend doing that exercise?	

Sexual History	
What best describes you currently? I am a virgin Multiple partners in the past I am sexually inactive Monogamous Multiple partners Sex for money Same sex encounters HIV partner	
Have you been sexually abused?	
Female Patients Only:	
When you have sex is it satisfactory for you?	
Are you satisfied with your vaginal lubrication during sexual intercourse?	
Do you experience discomfort or pain during vaginal penetration?	
Male Patients Only:	
Do you have difficulty with erections?	
Is it difficult to maintain your erection until completion?	
When you have sex is it satisfactory for you and your partner?	

Drug and Blood Transfusion:	
Describe your drug use: never, former, current	
If former or current, what type of drug(s)?	
Have you had a blood transfusion?	
If yes, what year?	

Home and Travel:	
Do you travel outside of the country?	
If yes, where?	
Do you have firearms in the house?	
Do you have smoke detectors in the home?	
Is there violence in your home?	
Do you feel safe at home?	

<u>Do you have complaints of any of the following</u> (circle or mark and x next to any that apply)

General Health			
Fever		Poor Appetite	
Chills		Sweats	
Fatigue		Weakness	
Excessive sweating		Not feeling well	
Loss of sensation		Headaches	
Confusion			

Eyes			
Blurring of your vision		Discharge of eyes	
Double vision		Vision loss	
Irritation of eyes		Eye pain	
Eyes sensitive to light			

Ear Nose and Throat			
Decreased hearing		Runny nose	
Dizziness		Ear ache	
Hoarseness		Ear discharge	
Nasal congestion		Ringing in the ears	
Sore throat		Nose bleeds	

Cardiovascular			
Chest pain		Shortness of breathe lying down	
Fainting		Shortness of breathe with exertion	
Pain in legs with exertion		Swelling of hands or feet	
Palpitations		Shortness of breathe at night	

Respiratory			
Chest pain		Wheezing	
Shortness of breath		Sleep disturbances due to breathing	
Cough		Chest discomfort	
Coughing up blood		Sleep problems	

Digestive			
Abdominal pain		Nausea	
Blood in stools		Vomiting blood	
Change in bowel habits		Heartburn	
Diarrhea		Difficulty Swallowing	
Frequent indigestion			

Genitourinary			
Abnormal vaginal discharge		Urinating during the night	
Painful urination		Frequent Urination	
Blood in your urine		Heavy periods	
Incontinence (unable to control urine or stool)		Severe menstrual cramps	

Musculoskeletal			
Back pain		Muscle cramps	
Joint pain		Stiffness	
Joint swelling		Muscle weakness	

Dermatological			
Rash		Change in moles	
Suspicious lesions			

Neurological			
Dizziness		Weakness	
Fainting		Seizures	
Headache		Tremors	
Numbness			

Psychological			
Anxiety		Thoughts of suicide	
Depression		Eating disorder	

Endocrine			
Cold intolerance		Heat intolerance	
Excessive urination		Abnormal weight change	
Excessive thirst			

Heme / Lymphatic			
Abnormal Bruising		Enlarged lymph nodes	
Bleeding			

Allergy			
Bee Stings		Hives	
Food Allergies		Persistent infections	

Family History (please check all that apply)

	Father	Mother	Sibling	Grandparent
Diabetes	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Angina	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Suicide	☐	☐	☐	☐
Other Health Problems	☐	☐	☐	☐

Adverse Childhood Experience (ACE) Questionnaire

Please complete this survey prior to your appointment at MidValley Family Practice. We are asking our patients to complete this survey to help Dr. Kotz understand how events in your life may impact your health and well being. Our goal is to provide the best care we can to you and the information provided in this will help us reach that goal. Your responses will be kept confidential with the Care Team.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …

   Swear at you, insult you, put you down, or humiliate you?

   or

   Act in a way that made you afraid that you might be physically hurt? ……..Yes ☐ No ☐

2. Did a parent or other adult in the household **often** …

   Push, grab, slap, or throw something at you?

   or

   Ever hit you so hard that you had marks or were injured?.....Yes ☐ No ☐

3. Did an adult or person at least 5 years older than you **ever**…

   Touch or fondle you or have you touch their body in a sexual way?

   or

   Try to or actually have oral, anal, or vaginal sex with you? ……Yes ☐ No ☐

4. Did you **often** feel that …

   No one in your family loved you or thought you were important or special?

   or

   Your family didn't look out for each other, feel close to each other, or support each other?..... ……Yes ☐ No ☐

5. Did you **often** feel that …

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   or

   Your parents were too drunk or high to take care of you or take you to the doctor

   if you needed it? ……..……Yes ☐ No ☐

6. Were your parents **ever** separated or divorced? ……..…Yes ☐ No ☐
7. Was your mother or stepmother:

   Often pushed, grabbed, slapped, or had something thrown at her?

   or

   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

   or

   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife? ……..Yes ☐ No ☐

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?.....Yes ☐ No ☐
9. Was a household member depressed or mentally ill or did a household member attempt suicide?.... Yes ☐ No ☐
10. Did a household member go to prison?..... Yes ☐ No ☐

For more information about ACE, please visit : http://acestudy.org/