

Please fill out this page if you are FEMALE. If you are not female, go to the next page.

Name: _____ Date: _____

DOB: _____

Review of Systems: Please checkmark any symptoms you are currently experiencing.

General

- ☐ chills
- ☐ daytime sleepiness
- ☐ fatigue
- ☐ fever
- ☐ loss of appetite
- ☐ malaise
- ☐ night sweats
- ☐ severe snoring
- ☐ trouble sleeping
- ☐ unexpected weight loss

Eyes

- ☐ blurred vision
- ☐ discharge
- ☐ double vision
- ☐ eye irritation
- ☐ eye pain
- ☐ light sensitivity
- ☐ loss of vision

Ears, Nose, & Throat

- ☐ decreased hearing
- ☐ difficulty swallowing
- ☐ ear discharge
- ☐ earache
- ☐ face or jaw pain
- ☐ hoarseness
- ☐ nasal congestion
- ☐ nosebleeds
- ☐ nasal discharge
- ☐ ringing in the ears
- ☐ sore throat

Cardiovascular

- ☐ chest pain or discomfort
- ☐ calf pain with walking
- ☐ difficulty breathing at night
- ☐ difficulty breathing laying down
- ☐ fainting or near fainting
- ☐ leg cramps
- ☐ lightheadedness
- ☐ discomfort breathing relieved by sitting or standing
- ☐ palpitations or racing heart
- ☐ hard time breathing when lying down
- ☐ peripheral edema
- ☐ recent weight gain
- ☐ shortness of breath with exertion
- ☐ swelling in extremities
- ☐ syncope

Breast

- ☐ abnormal mammogram
- ☐ bloody discharge from nipple
- ☐ breast enlargement
- ☐ breast pain
- ☐ breast lump
- ☐ nipple discharge

Respiratory

- ☐ chest pain with deep breaths
- ☐ cough
- ☐ coughing up blood
- ☐ excessive mucus or phlegm
- ☐ excessive snoring
- ☐ excessive sputum
- ☐ hemoptysis
- ☐ pleuritic chest pain
- ☐ shortness of breath
- ☐ wheezing

Gastrointestinal

- ☐ abdominal bloating
- ☐ abdominal pain
- ☐ bloody stools
- ☐ change in bowel movements
- ☐ constipation
- ☐ black tarry stools
- ☐ diarrhea
- ☐ trouble swallowing
- ☐ heartburn
- ☐ hemorrhoids
- ☐ indigestion
- ☐ nausea
- ☐ pain with swallowing
- ☐ vomiting
- ☐ vomiting blood
- ☐ yellowish skin color

Genitourinary - Women

- ☐ blood in urine
- ☐ decreased sex drive
- ☐ discharge
- ☐ pain with urination
- ☐ genital sores
- ☐ heavy or prolonged periods
- ☐ hot flashes
- ☐ irregular or missed periods
- ☐ nighttime urination
- ☐ pain with intercourse
- ☐ painful periods
- ☐ pelvic pain
- ☐ spotting
- ☐ trouble starting urinary system
- ☐ urinary frequency
- ☐ urinary hesitancy
- ☐ urinary urgency
- ☐ urinary incontinence

Musculoskeletal

- ☐ neck pain
- ☐ thoracic pain
- ☐ lumbar pain
- ☐ general weakness
- ☐ joint pain
- ☐ joint swelling
- ☐ muscle aches
- ☐ muscle cramps
- ☐ muscle weakness
- ☐ stiffness

Skin

- ☐ change in hair or nails
- ☐ dry skin
- ☐ excessive perspiration
- ☐ itching
- ☐ non-healing sores
- ☐ rash
- ☐ skin cancer
- ☐ suspicious lesions
- ☐ unusual hair distribution

Neurologic

- ☐ arm or leg weakness
- ☐ confusion
- ☐ dizziness or sensation of spinning
- ☐ facial weakness
- ☐ falling down
- ☐ headaches
- ☐ loss of consciousness
- ☐ numbness or tingling
- ☐ poor balance or coordination
- ☐ poor memory
- ☐ seizures or uncontrolled movements
- ☐ slurred speech
- ☐ tremors
- ☐ trouble concentrating
- ☐ visual disturbances

Mental Health

- ☐ depressed mood
- ☐ anxious mood
- ☐ fears or phobias
- ☐ frightening visions or sounds
- ☐ thoughts of suicide
- ☐ thoughts of violence to others

Endocrine

- ☐ intolerance to cold
- ☐ intolerance to heat
- ☐ excessive hunger
- ☐ excessive thirst
- ☐ excessive urination

Blood

- ☐ enlarged glands
- ☐ excessive or easy bruising
- ☐ prolonged bleeding

Allergy

- ☐ hives or rash
- ☐ persistent infections
- ☐ possible HIV exposure
- ☐ seasonal allergies

Other:

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Genitourinary - Men

- ☐ blood in urine
- ☐ decreased libido
- ☐ discharge
- ☐ pain with urination
- ☐ erectile dysfunction
- ☐ genital sores
- ☐ nighttime urination
- ☐ trouble starting urination
- ☐ urinary frequency
- ☐ urinary hesitancy
- ☐ urinary urgency
- ☐ urinary incontinence

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Medicare Exam Screening Questionnaire

Depression Screen:

Over the past two weeks have you felt down, depressed, or hopeless? [☐] Yes [☐] No

Over the past two weeks, have you felt little interest or pleasure in doing things? [☐] Yes [☐] No

Fall Prevention:

Do you have a history of falling within the prior 12 months? [☐] Yes [☐] No

Do you require an ambulatory aid when walking? [☐] Yes [☐] No

Do you experience low blood pressure (hypotension)? [☐] Yes [☐] No

Do you have gait/balance problems or lower extremity weakness? [☐] Yes [☐] No

Do you have risk factors at home (e.g., loose rugs, inadequate grab rails, poor lighting)? [☐] Yes [☐] No

Hearing Screen:

Do you have trouble hearing the television or radio when other do not? [☐] Yes [☐] No

Hearing device: [☐] Yes [☐] No

Do you strain or struggle to hear/ understand conversations? [☐] Yes [☐] No

Functional Ability/Screening:

Do you need help with any of these daily activities? (Circle **all that apply**) [☐] Yes [☐] No
telephone, transportation, shopping, meals, housework, laundry,
medications or managing money?

Nutrition Screening:

Have you had any unintentional weight loss? [☐] Yes [☐] No

Do you have a problem with appetite, chewing or swallowing? [☐] Yes [☐] No

Do you have trouble getting food because of limited finances,
mobility, or mental status? [☐] Yes [☐] No

Have you had a prolonged hospitalization, major surgery or serious infection? [☐] Yes [☐] No

Do your medical problems or medications affect nutrition? [☐] Yes [☐] No

Physical Health:

Do you have regular exercise program? [☐] Yes [☐] No

Would you like to discuss participation in a physical
fitness program? [☐] Yes [☐] No

Bladder Control:

Do you have trouble with urinary leakage? [☐] Yes [☐] No

Would you like to discuss treatment options? [☐] Yes [☐] No

Nine Symptom Checklist

Please answer **EVERY** question with only **ONE** choice.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things.				
b. Feeling down, depressed, or hopeless.				
c. Trouble falling/staying asleep, sleeping too much.				
d. Feeling tired or having little energy.				
e. Poor appetite or overeating.				
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
g. Trouble concentrating on things, such as reading the newspaper or watching television.				
h. 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.				
i. Thoughts that you would be better off dead or of hurting yourself in some way.				

Total Score: _____

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



Western Washington
Medical Group

Whitehorse Family Medicine

WELLNESS EXAM

Name: _____ DOB: _____ Date: _____

Pain Screening:

Pain Screening? ☐ Yes ☐ No

If Yes,

Location on body: _____

Intensity (circle one): 1 2 3 4 5 6 7 8 9 10

Type:

☐ sharp ☐ stinging ☐ dull ☐ burning ☐ aching ☐ heaviness ☐ numbness ☐ tingling

Have you taken any pain medication (opioids) since your last visit (within the last 6 months)?

☐ Yes ☐ No

If Yes: Please indicate the **name of the pain medication(s)** and **reason** for taking them:

Medication	Reason

Are you currently taking the pain medication(s)?

☐ Yes ☐ No