PLEASE ARRIVE EARLY TO COMPLETE THIS ONE PAGE PRIOR TO EVERY APPOINTMENT

Patient Name: _____ Date: _____/_____/_____ Age: _____ DOB: _____/_____/_____

Review of Systems/Symptoms: (Circle any current symptoms within the last **TWO WEEKS** or check **NONE**)

Systems	**Signs/Symptoms**				
1. General/Constitutional	☐ None	Fevers	Weight Loss	Weight Gain	Other:
2. Eyes	☐ None	New Blurred Vision			Other:
3. Ears/Nose/Mouth/Throat	☐ None	Dry Mouth	Ears Ringing		Other:
4. Cardiovascular	☐ None	Fast Heart Rate	Chest Pain	Chest Tightness	Other:
5. Respiratory	☐ None	Shortness of Breath		Cough	Other:
6. Gastrointestinal	☐ None	Constipation	Diarrhea	Nausea/Vomiting	Other:
7. Genitourinary	☐ None	Urinary Problems	Low Libido		Other:
8. Muscular/Skeletal	☐ None	Muscle/Joint Pain	Weakness	Falls	Other:
9. Integumentary/Skin	☐ None	Increased Sweating		Rash	Other:
10. Neurological	☐ None	Memory Problems	Headache	Dizziness	Other:
11. Endocrine	☐ None	Heat/Cold Intolerance		Tremor	Other:
12. Hematologic/Lymphatic	☐ None	Easy Bruising/Bleeding		Blood Clots	Other:
13. Allergies/Immune	☐ None	Anaphylactic Shock		Hives	Other:
14. Psychiatric	See Below				

PHQ-9 (Modified Mood/Depression Rating Scale)

Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems? *(CIRCLE the # 0, 1, 2, OR 3 for each row/question)*	**Not at All**	**Several days**	**More than half the days**	**Nearly every Day**
1. Felt down, depressed, sad, tearful, and/or hopeless	0	1	2	3
2. Trouble falling asleep, staying asleep, waking up too early, OR sleeping too much	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Felt worthless, hopeless, helpless, guilt, and/or failure	0	1	2	3
5. Low energy, feeling tired, or fatigued	0	1	2	3
6. Trouble with concentration (watching TV, reading, work, etc…), indecisiveness, and/or maintaining focus	0	1	2	3
7. Poor appetite or overeating	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed; OR, the opposite, feeling so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
9. Thoughts of not wanting to be alive, wishing to be dead, or considering harming yourself	0	1	2	3
ADD EACH CIRCLED COLUMN	-	+	+	
OVERALL TOTAL =				

10. If you circled ANY problem(s) above, how difficult has it been to do your work, take care of things at home, or get along with other people? *(**Check ONE** answer to the **right**)*	Not difficult at all ☐	Somewhat difficult ☐	Very Difficult ☐	Extremely difficult ☐

GAD-7 (Modified Anxiety Rating Scale)

Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems? *(CIRCLE the # 0, 1, 2, OR 3 for each row/question)*	**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
ADD EACH CIRCLED COLUMN	-	+	+	
OVERALL TOTAL =				

8. If you circled ANY problem(s) above, how difficult has it been to do your work, take care of things at home, or get along with other people? *(**Check ONE** answer to the **right**)*	Not difficult at all ☐	Somewhat difficult ☐	Very Difficult ☐	Extremely difficult ☐