UB|MD INTERNAL MEDICINE

PRIMARY CARE ONLY

PATIENT NAME	BIRTH DATE / /

IMMUNIZATIONS & PREVENTIVE SERVICES *Check all that apply and PROVIDE DATE received*

PLEASE NOTE: All patients under 18 must have vaccine records either attached or transferred by previous MD

	DATE/Yr.
☐ **NONE**	
☐ Flu vaccine	_____
☐ MMR	_____
☐ Tetanus	_____
☐ Prevnar vaccine	_____
☐ Pneumovax 23 vaccine	_____
☐ Hepatitis B vaccines	_____
☐ HPV vaccine	_____
☐ Hepatitis A vaccines	_____
☐ Zoster Vaccine	_____

	DATE/Yr.
☐ Last bloodwork	_____
Where:	_____
☐ HIV Testing	_____
☐ Hepatitis C Testing	_____
☐ STD Testing	_____
☐ Hearing test	_____
☐ Eye exam	_____
☐ Dental exam	_____
☐ OTHER	_____
☐ OTHER	_____

	DATE/Yr.
☐ PAP smear	_____
☐ Mammogram	_____
Where:	_____
☐ Bone density test	_____
☐ Colonoscopy	_____
Where:	_____
Who:	_____
☐ Abdominal Aortic Aneurysm Screening	
Date/Yr:	_____
Where:	_____

PERSONAL HABITS *Please complete the following information about yourself.*

Do you wear a seatbelt? Always / Occasionally / Never

Do you talk/text on phone while driving? Y / N

Do you have a smoke detector? Y / N

Do you have a carbon monoxide detector? Y / N

Do you have any unsecured guns in the home? Y / N

Would you like to be screened for HIV or sexually transmitted diseases? Y / N

Do you eat 5 or more servings of fruit and vegetables most days? Y / N

GOAL SETTING *Please complete the following information about yourself.*

What are your healthcare goals for this year? (Examples include: exercise 3 days per week; be able to kneel down and play with my grandchildren.) _____

How do you plan to accomplish these goals? _____

What are the barriers, if any? (Examples include lack of healthy food, knowledge, lack of outside exercise or play time, no safe outside environment, family distractors, genetics)

_____

_____

PHQ-2 *Please complete the following information about yourself.*

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

1) Little interest or pleasure in doing things: ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

2) Feeling down, depressed, or hopeless: ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

SIGNATURE

_____ _____

Signature **Date**

If completed by someone other than the patient:

Your Name:_____ **Relationship:**_____