VILLAGE
INTERNAL MEDICINE GROUP

Lisa E. Medwedeff M.D. Gracie Martinez –FNP C Winona Tzou-FNP

Today's Date: _____.

Name: _____ **Date of Birth:** _____.

Occupation/Profession: _____.

Marital Status: _____.

__ Single __ Married __ Widowed __ Divorce __ Separated __ Engaged __ Domestic partner

Tabacco History:

__ Current Smoker __ Former Smoker __ Social Smoker __ Never Smoked

Smoked _____ packs/day for _____ years.

I quit smoking _____ years ago. If yes, what method? _____.

Cigars: __ Yes __ No

Chewing Tabacco: __ Yes __ No

E-Cig: __ Yes __ No

Alcohol:

__ None __ Rarely __ Occasional __ Everyday __ Socially

Number of drinks _____ day/week/month/year.

Current Medication (Please include prescription, over the counter, and vitamins)

Name	Dose	Date Started	Condition treating

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Allergies

Drug	Reaction

Self and family history

Mark the columns that apply	None	Self	Father	Mother	Brother	Syster	Son	Daughter
Congestive heart failure								
Arrhythmia								
Diabetes								
High cholesterol								
Thyroid								
COPD (chronic lung disease)								
Asthma								
High blood pressure								
Stroke								
Kidney disease								
Arthritis								
Osteoporosis								
Osteopenia								
Obesity								
Liver disease								
Kidney disease								
Cataract								
Depression								
Anxiety								
Bipolar disorder								
Schizophrenia								
Dementia								
Cancer								

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Surgical History

Date	Surgery

Hospitalization

Date	Reason

Immunizations	Date	Notes
COVID		
Tdap (Tetanus-Diphtheria-Pertussis)		
Pneumo 23 (Pneumonia)		
Prevnar 13		
Influenza/Flu		
Shingrix (Shingles)		
Hep A		
Hep B		
PPD		
Varicella		
HPV		

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Preventive medicine	Date	Results	Performed by:
Physical Exam			
Medicare Wellness (>65)			
Full labs			
Mammogram (If applicable)			
Pap Smear/HPV (If applicable)			
Bone Density (If applicable)			
PSA (If applicable)			
Colonoscopy/FOBT			
Last eye exam/Retinopathy			
Nephropathy/Urine Microalb/Cr ratio			
DM Foot Exam			
Neuropathy			
Last Fall			

Physicians or Health Care Providers

Specialty	Physician name	Date last seen
Cardiologist		
Pulmonologist		
Eye doctor		
Endocrinologist		
Physical therapist		
Gynecologist		
Dermatologist		
Ear, nose, and throat		

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Patient's Name: _____ Today's Date: _____

General Sense of well-being: __ Good __ Poor Energy level: __ Good __ Poor __ Fever __ Chills __ Night Sweats __ Weight Loss __ Weight Gain __ Change in Sleep __ Insomnia	**Gastrointestinal** __ Changes in Appetite __ Trouble chewing or swallowing __ Heartburn/Reflux __ Nausea __ Indigestion __ Vomiting __ Diarrhea __ Constipation __ Hemorrhoids __ Increased Gas/Bloating __ Change in Bowel Movements __ Bloody/Black Stools __ Chalky Stools __ Mucous in Stools __ Abdominal pain __ Yellowish Eyes/Skin
Skin __ Dry skin __ Discoloration __ Acne __ Moles __ Lumps __ Rashes __ Eczema __ Psoriasis __ Hives	**Genitourinary** __ Urinary Burning __ Excessive Night Urination (# times/night __) __ Difficulty Starting/Stopping Stream __ Decreased Urinary Stream __ Leakage __ Genital Lesions __ Discharge __ Sexual Dysfunction
Eyes __ Irritation __ Pain __ Swelling __ Redness __ Double Vision __ Blurred Vision __ Spots __ Blank areas	**Endocrine** __ Heat/Cold Intolerance __ Excessive Thirst __ Excessive Urination __ Excessive Dry/Oily Skin __ Excessive Hair Growth/Loss
Ears __ Pain __ Hearing problems __ Hearing Aids Ringing __ Drainage	**Hematology** __ Easy Bruising __ Prolong Bleeding
Nose __ Allergies __ Sinus pain __ Nasal discharge __ Bleeding __ Deviated septum __ Decreased sense of smell __ Polyps	**Peripheral Vascular** __ Leg Swelling __ Leg pain when walking __ Cold Feet __ Varicose Veins __ Leg Cramping
Throat/Mouth __ Fever Blisters __ Canker Sores __ Tongue Problems __ Dentures __ Snoring __ Sore throat __ Swollen Glands __ Dry Mouth	**Neurology** __ Headaches (# per month __) __ Confusion __ Seizures __ Dizziness __ Tremor __ Numbness/Tingling __ Gait Abnormality __ Balance Difficulty __ Fainting __ Memory Loss
Pulmonary __ Wheezing __ Shortness of Breath __ Phlegm __ Cough __ Coughing up Blood __ Pain with Inspiration __ Emphysema __ Pneumonia __ Bronchitis	**Musculo/Skeletal** __ Joint Pain __ Joint Swelling __ Joint Tenderness __ Weakness __ Ache __ Stiffness __ Decreased range of motion __ Injury Shoulder/Arm/Hip/Knee/Ankle
Heart __ Chest Pain __ Palpitations (racing heart) __ Irregular Heartbeats __ Heart Murmur __ Hypotension __ Leg Swelling __ Difficulty lying flat __ Decreased ability to exercise	**Mental Health** __ Sadness __ Feeling anxious __ Chemical Dependence/Abuse __ Forgetful __ Cognitive Changes __ Depressed Mood

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Patient's Name: _____ **Today's Date:** _____

For the following questions please answer with this scale:

	Poor	Fair	Good	Very Good	Excellent
Overall, describe your health.					
Overall, describe your quality of life.					
Overall, describe your mental health, taking into consideration your mood and cognitive ability.					

For the following questions please answer Yes or No.

	Yes	No
Have you experienced urinary incontinence within the past 6 months?		
Have you fallen within the past 12 months?		
Do you have any issues with hearing or are you perceived to have hearing issues?		
Does your eyesight hinder your ability to read, watch television, drive, or perform any other day-to-day tasks?		

In your home have the following safety measures been taken?

	Yes	No
Secured loose rugs and/or carpets		
Functioning carbon monoxide detector		
Functioning smoke alarm		
Well-lit walking areas		
Sturdy stair rails		
Anti-slip floors in shower/bathtub or grab bars in bathroom		

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Please describe your ambulation/mobility status (Please list any use of mobility assistive devices i.e., cane, walker, wheelchair, mobility scooter):

_____

Mode of transportation:

___I drive myself ___Someone else drives me ___I use public transportation, Uber, Lyft, etc.,

What is the typical serving of vegetable and/or fruits you consume daily?

___ >5 servings ___ 3-5 servings ___ 1-2 servings ___None

	Yes	No
Do you have an Advance Directive (power of attorney and living will)?		
If yes, do you have your Advance Directive in your records with us?		

Patient Name:_____ **Date:**_____

Patient ID #_____

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	Independence (1 Point) **NO** supervision, direction or personal assistance.	Dependence (0 Points) **WITH** supervision, direction, personal assistance or total care.
BATHING Points: _____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS: _____ **SCORING:** 6 = High (*patient independent*) 0 = Low (*patient very dependent*

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