Patient Health History/C.C. Hutton, MD

Patient name/Date of birth: ____

Today's date: ________________________Date of last physical examination: ________________________

Symptoms you have had over the past few months:

GENERAL

__ chills
__ fainting
__ fever
__ loss of weight
__ numbness
__ sweats

EYE/EAR/NOSE/THROAT

__ bleeding gums
__ blurred vision
__ crossed eyes
__ double vision
__ difficulty swallowing
__ hoarseness
__ earache
__ ear discharge
__ ringing in the ears
__ loss of hearing
__ hay fever
__ nosebleeds
__ sinus problems

CARDIOVASCULAR

__ chest pain
__ high blood pressure
__ low blood pressure
__ irregular heart beat
__ rapid heart beat
__ poor circulation
__ swelling in ankles
__ high cholesterol

RESPIRATORY

__ persistent cough
__ shortness of breath
__ decrease in exercise capacity

GASTROINTESTINAL

__ abdominal pain
__ poor appetite
__ bloating
__ bowel changes
__ constipation
__ diarrhea
__ gas
__ heartburn/indigestion
__ hemorrhoids
__ nausea
__ vomiting

GENITOURINARY

__ blood in urine
__ frequent urination
__ painful urination
__ lack of bladder control

MUSCLE/JOINT/BONE

pain/weakness/numbness
__ neck
__ shoulders
__ back
__ arms __ hands
__ hips __ legs __ feet

SKIN

__ bruises easily
__ hives
__ itching
__ changes in moles
__ rash
__ scars
__ sores that won't heal

NEUROLOGICAL

__ dizziness
__ lightheadedness
__ weakness
__ fainting
__ seizures

PSYCHIATRIC

__ depression
__ headaches
__ loss of sleep
__ nervousness
__ stress
__ trouble concentrating

ENDOCRINE

__ diabetes
__ hypertension
__ thyroid disease

ALLERGIES

__ asthma
__ allergic rhinitis

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Patient name/Date of birth: ____

WOMEN	MEN
__ abnormal pap smear	__ erection difficulties
__ bleeding between periods	__ lump in testicles
__ breast lump	__ discharge from penis
__ extreme menstrual pain	date of last prostate exam: ____________________
__ hot flashes	
__ nipple discharge	
__ vaginal discharge	
__ painful intercourse	
Currently pregnant: __ yes __ no	

Do you have a personal history of ever having:

__ AIDS/HIV	__ emphysema	__ polio
__ alcoholism	__ COPD	__ enlarged prostate
__ anemia	__ tuberculosis	__ prostate cancer
__ anorexia	__ pneumonia	__ psychiatric care
__ appendicitis	__ herpes	__ tonsillitis
__ arthritis	__ gonorrhea	__ ulcers
__ asthma	__ venereal disease	__ epilepsy/seizures
__ bronchitis	__ coronary artery disease	__ gout
__bulimia	__ heart valve disease	__ glaucoma
__ cancer	__ peripheral vascular disease	__measles
Type: _________________	__ pacemaker	__ mumps
__ cataracts	__ mononucleosis	__ scarlet fever
__ chemical dependency	__ hepatitis/type: __________	__ typhoid fever
__ chicken pox	__ kidney disease	__ Rheumatic fever
__ shingles	__ dialysis	__ liver disease
__ measles	__ liver disease	__ migraines
__ mumps	__ hernia	__ miscarriage

SOCIAL HISTORY Caffeine use: ___________________ Alcohol use: __________________

Do you smoke? __ no/never Recreational drug use: __ no __ yes/type: _______________

__ no/not currently; When did you quit? _____________ How much did you smoke before you quit?

____

__ yes At what age did you start smoking? _______ How much do you smoke? ________

Patient Health History/C.C. Hutton, MD/Page 3

Patient name/Date of birth: ____

What kind of surgeries have you ever had?

____

____

____

____

____

Family history: age state of health age at death cause of death

Mother ____

Father ____

_____ sisters ____

_____ brothers ____

_____ daughters ____

_____ sons ____

Family history was also positive for: ____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

____

Patient signature Date completed

____

Physician signature Date reviewed

Patient name:____

Date of birth: ____

General Consent for Care and Treatment Consent/C.C. Hutton, MD

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concern regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____	____________________________________
Signature of patient or personal representative	Date
____	____________________________________
Printed name of patient or personal representative	Relationship to patient
____	_____________________________________
Printed name of witness	Employee job title
____	_____________________________________
Signature of witness	Date

Date: _________________ **Patient Medication List/C.C. Hutton, MD**

Patient name/Date of birth: ____

Known allergies/sensitivities: ____

Medication:	Dosage:	Taken how often:

Provider: **C.C. Hutton, MD** **Fall Risk Assessment** age 65 and older

*Please Note: This screening is required by federal mandate to be completed annually.

Patient Name/Date of Birth: ____

Date: ___________________________

Increased Fall Risk Factors (check all that apply):

____ Diagnoses (Do you have 3 or more existing medical conditions?)

____ Do you have a prior history of falls within the past 3 months?

____ Incontinence (Do you have an uncontrolled bladder?)

____ Visual impairment (Do you have trouble seeing?)

____ Impaired functional movement (Do you use a cane or walker?)

____ Environmental hazard (Do you have stairs or loose rugs in your home?)

____ Polypharmacy (Do you take more than 3 medications?)

____ Pain affecting level of function (Does pain keep you from performing your daily activities?)

____ None of the above

History of falls in the past year? Yes No

If yes, how many? __________________ When: (month/year) ____________________________

Did you get hurt? Yes No

Did you see your PCP or go to the ER? ____

Have you had a colonoscopy or Cologuard test in the past 10 years? Yes No

When: ________________________

Have you had a mammogram in the past 2 years? Yes No

When: ________________________

Have you had a pap smear in the past 3 years? Yes No N/A male

When: ________________________

Have you had a pneumonia shot in the past 5 years? Yes No

When: ________________________

Date: _________________

Patient Health Depression Questionnaire (PHQ-9)/C.C. Hutton, MD

Patient name/Date of birth: ____________________________________

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

	Not at all 0	several days 1	>1-2 days 2	nearly daily 3
Little interest or pleasure in doing things	_____	_____	_____	_____
Feeling down, depressed, or hopeless	_____	_____	_____	_____
Trouble falling or staying asleep, or sleeping too much	_____	_____	_____	_____
Feeling tired or having little energy	_____	_____	_____	_____
Poor appetite or overeating	_____	_____	_____	_____
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	_____	_____	_____	_____
Trouble concentrating on things, such as reading the newspaper or watching TV	_____	_____	_____	_____
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	_____	_____	_____	_____
Thoughts that you would be better off dead, or of hurting yourself in some way	_____	_____	_____	_____

Provider: **C.C. Hutton, MD** SOGI FORM

Appointment Date:___________________________________

Patient Name/Date of Birth: ____

Birth Sex: ____ male ____ female ____ unknown

Sexual Orientation:

Name	SNOMED
____ Lesbian, gay, or homosexual	38628009
____ Straight or heterosexual	20430005
____ Bisexual	42035005
____ Do not know	UNK
____ Choose not to disclose	ASKU
____ Something else, please describe:	OTH

Gender Identity:

____ male	446151000124109
____ female	446141000124109
____ female-to-male/transgender male/trans man	407377005
____ male-to-female/transgender female/trans woman	407376001
____ genderqueer, neither exclusively male nor female	446131000124102
____ choose not to disclose	ASKU
____ additional gender category/other, please specify	OTH
____ transgender	