Patient Information

Identifying Information:

Client Name:____________________________________ Date of Birth: ___________________________________

Age:____ Gender: _______________________________________

Race: ____ Residence (City): _______________________________

Medication Allergies:______________________________ Marital Status: M D S W

Occupation:_____________________________________ Currently Employed: Y N

PCP: ____ Pharmacy #: ____________________________________

Presenting Problems:

Brief Description of Current Problems:

____

____

____

Psychiatric medications (use an additional page if necessary)

Current:

Med: ____________________________ Dose:________________ Frequency:_______________ Duration:______________

Med: ____________________________ Dose:________________ Frequency:_______________ Duration:______________

Med: ____________________________ Dose:________________ Frequency:_______________ Duration:______________

Med: ____________________________ Dose:________________ Frequency:_______________ Duration:______________

Past: ____

Other Medications: (to include Vitamins, Herbals, etc.)

____

Past Treatment:

Current/Past psychiatric diagnosis: ____

Previous Psychiatric Treatment:

In-Patient: When: _______________________ When: _________________________

Where: ______________________ Where: ________________________

Why: ________________________ Why: __________________________

Out-Patient: When: _______________________ When: _________________________

Where: ______________________ Where: _________________________

Suicide Attempts: Y N If yes, ____

Habits:

Tobacco: ________ppd: _________ years: __________ Alcohol current: ________________Past: ___________________

Caffeine ______cups coffee/day ______colas/day ______glasses of tea/day

Substance Abuse:

Please circle: None Past Present

Substance Used: ___________________________________ Age of Onset: _________________________

Amount/Frequency of Use: __________________________ Length of Use: ________________________

Consequences of Use: ____

Medical History:

Developmental Delays: Y N If yes: ______________________________

Current/Chronic Illness: Y N If yes:

____

____

Surgeries: Y N If yes, ______________________________

Head Injuries/Seizures: Y N If yes: ______________________________

Difficulties during Delivery/Pregnancy: Y N If yes: ______________________________

Current Nutritional Status: Weight: ______________ Height: ______________

Female Only: Age of onset of period:_________ Last period: __________ Birth control: ______________

Age of Menopause: __________ Hormone replacement: ______________

Family History:

Medical: Mother side: ______________________________

Father side: ______________________________

Sibling/Children: ______________________________

Social History:

Current residence (City/State): ______________________________

Name/Age of children: ______________________________

#/Duration of Marriages: ______________________________

Who lives in the home:

____

____

Childhood History:

Where were you born and raised: ______________________________

Level of Education: ______________________________

Number of siblings: Brothers: ______________ Sisters: ______________

Relationships:

Abuse: Physical/Sexual/Emotional Y N If yes,

____

____

Financial Issues: Y N If yes: ______________________________

Legal Issues: Y N If yes: ______________________________

______________________________ ______________________________

Patient Signature Date

I have reviewed with patient and revised as needed the above patient information: Y N

______________________________ ______________________________

Physician Signature Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: ______________________________ **DATE:** ____________

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	____ +	____ +	____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: ____________

10. 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	________

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A2663B 10-04-2005

Edinburgh Postnatal Depression Scale (EPDS)

Name: ________________________________

Your Date of Birth: ________________________

Baby's Date of Birth: ________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

GAD-7 Anxiety

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer")*	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

Column totals: ___ **+** ___ **+** ___ **+** ___

= ***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**
☐	☐	☐	☐

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

OCI-R

The following statements refer to experiences that many people have in their everyday lives. Circle the number that best describes **HOW MUCH** that experience has **DISTRESSED or BOTHERED you during the PAST MONTH.** The numbers refer to the following verbal labels:

0 Not at all	1 A little	2 Moderately	3 A lot	4 Extremely

1.	I have saved up so many things that they get in the way.	0	1	2	3	4
2.	I check things more often than necessary.	0	1	2	3	4
3.	I get upset if objects are not arranged properly.	0	1	2	3	4
4.	I feel compelled to count while I am doing things.	0	1	2	3	4
5.	I find it difficult to touch an object when I know it has been touched by strangers or certain people.	0	1	2	3	4
6.	I find it difficult to control my own thoughts.	0	1	2	3	4
7.	I collect things I don't need.	0	1	2	3	4
8.	I repeatedly check doors, windows, drawers, etc.	0	1	2	3	4
9.	I get upset if others change the way I have arranged things.	0	1	2	3	4
10.	I feel I have to repeat certain numbers.	0	1	2	3	4
11.	I sometimes have to wash or clean myself simply because I feel contaminated.	0	1	2	3	4
12.	I am upset by unpleasant thoughts that come into my mind against my will.	0	1	2	3	4
13.	I avoid throwing things away because I am afraid I might need them later.	0	1	2	3	4
14.	I repeatedly check gas and water taps and light switches after turning them off.	0	1	2	3	4
15.	I need things to be arranged in a particular way.	0	1	2	3	4
16.	I feel that there are good and bad numbers.	0	1	2	3	4
17.	I wash my hands more often and longer than necessary.	0	1	2	3	4
18.	I frequently get nasty thoughts and have difficulty in getting rid of them.	0	1	2	3	4

PTSD Checklist DSM5 (PCL-5) – Adult (18+)

Name: ______________________________ **Date:** ________________

Stressful or scary events happen to many people. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to you. Mark No if it didn't happen to you.

	Event	Yes	No
1.	Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐ Yes	☐ No
2.	Serious accident or injury like a car/bike crash, dog bite, sports injury.	☐ Yes	☐ No
3.	Robbed by threat, force or weapon.	☐ Yes	☐ No
4.	Slapped, punched, or beat up in your family.	☐ Yes	☐ No
5.	Slapped, punched, or beat up by someone not in your family.	☐ Yes	☐ No
6.	Seeing someone in your family get slapped, punched or beat up.	☐ Yes	☐ No
7.	Seeing someone in the community get slapped, punched or beat up.	☐ Yes	☐ No
8.	Someone older touching your private parts when they shouldn't.	☐ Yes	☐ No
9.	Someone forcing or pressuring sex, or when you couldn't say no.	☐ Yes	☐ No
10.	Someone close to you dying suddenly or violently.	☐ Yes	☐ No
11.	Attacked, stabbed, shot at or hurt badly.	☐ Yes	☐ No
12.	Seeing someone attacked, stabbed, shot at, hurt badly or killed.	☐ Yes	☐ No
13.	Stressful or scary medical procedure.	☐ Yes	☐ No
14.	Being around war.	☐ Yes	☐ No
15.	Other stressful or scary event?	☐ Yes	☐ No

Describe: ____

Which one is bothering you the most now? ___________________

If you marked "YES" to any stressful or scary events, then turn the page and answer the next questions.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Mood Disorder Questionnaire

Patient Name ______________________ Date of Visit ____________

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	**YES**	**NO**
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

Rapid Mood Screener (RMS)

Are you among the millions of people who have depressive symptoms? Answer the following questionnaire about your medical history and provide it to your doctor or nurse to assist in an important conversation about your mood.

Please select one response for each question. You can complete the **RMS** in less than 2 minutes.

Patient Name ________________________________ Date ________________

	YES	NO
1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	☐	☐
2. Did you have problems with depression before the age of 18?	☐	☐
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	☐	☐
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	☐	☐
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	☐	☐
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	☐	☐

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ADULT ADHD SELF-REPORT SCALE (ASRS-V1.1) SYMPTOM CHECKLIST

Patient: ______________________________ Date Completed: ______________

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during your appointment.	Never	Rarely	Sometimes	Often	Very often
PART A					
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					
PART B					
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or at work?					
How often are you distracted by activity or noise around you?					
How often do you leave your seat in meetings or in other situations in which you are expected to stay seated?					
How often do you feel restless or fidgety?					
How often do you have difficulty unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much when you are in social situations?					
When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish it themselves?					
How often do you have difficulty waiting your turn in situations when turn taking is required?					
How often do you interrupt others when they are busy?					

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Wender Utah Rating Scale for the Attention Deficit Hyperactivity Disorder

Overview:

The Wender Utah Rating Scale can be used to assess adults for Attention Deficit Hyperactivity Disorder with a subset of 25 questions associated with that diagnosis.

Wender Utah Rating Scale

- 61 questions answered by the adult patient recalling his or her childhood behavior
- 5 possible responses scored from 0 to 4 points

	As a child I was (or had):	not at all or very slightly	mildly	moder-ately	quite a bit	very much
1	active restless always on the go	0	1	2	3	4
2	afraid of things	0	1	2	3	4
3	concentration problems easily distracted	0	1	2	3	4
4	anxious worrying	0	1	2	3	4
5	nervous fidgety	0	1	2	3	4
6	inattentive daydreaming	0	1	2	3	4
7	hot- or short-tempered low boiling point	0	1	2	3	4
8	shy sensitive	0	1	2	3	4
9	temper outbursts tantrums	0	1	2	3	4
10	trouble with stick-to-it-tiveness not following through. failing to finish things started	0	1	2	3	4
11	stubborn strong-willed	0	1	2	3	4
12	sad or blue depressed unhappy	0	1	2	3	4
13	incautious. dare-devilish involved in pranks	0	1	2	3	4
14	not getting a kick out of things dissatisfied with life	0	1	2	3	4
15	disobedient with parents rebellious sassy	0	1	2	3	4
16	low opinion of myself	0	1	2	3	4
17	irritable	0	1	2	3	4

		not at all or very slightly	mildly	moder-ately	quite a bit	very much
18	outgoing friendly enjoyed company of people	0	1	2	3	4
19	sloppy disorganized	0	1	2	3	4
20	moody ups and downs	0	1	2	3	4
21	angry	0	1	2	3	4
22	friends popular	0	1	2	3	4
23	well-organized tidy neat	0	1	2	3	4
24	acting without thinking impulsive	0	1	2	3	4
25	tendency to be immature	0	1	2	3	4
26	guilty feelings regretful	0	1	2	3	4
27	losing control of myself	0	1	2	3	4
28	tendency to be or act irrational	0	1	2	3	4
29	unpopular with other children didn't keep friends for long didn't get along with other children	0	1	2	3	4
30	poorly coordinated did not participate in sports	0	1	2	3	4
31	afraid of losing control of self	0	1	2	3	4
32	well-coordinated picked first in games	0	1	2	3	4
33	tomboyish (for women only)	0	1	2	3	4
34	running away from home	0	1	2	3	4
35	getting into fights	0	1	2	3	4
36	teasing other children	0	1	2	3	4
37	leader bossy	0	1	2	3	4
38	difficulty getting awake	0	1	2	3	4
39	follower led around too much	0	1	2	3	4
40	trouble seeing things from someone else's point of view	0	1	2	3	4
41	trouble with authorities trouble with school visits to principal's office	0	1	2	3	4
42	trouble with police booked convicted	0	1	2	3	4

	Medical problems as a child	not at all or very slightly	mildly	moder-ately	quite a bit	very much
43	headaches	0	1	2	3	4
44	stomachaches	0	1	2	3	4
45	constipation	0	1	2	3	4
46	diarrhea	0	1	2	3	4
47	food allergies	0	1	2	3	4
48	other allergies	0	1	2	3	4
49	bedwetting	0	1	2	3	4
	As a child in school I was (or had)	not at all or very slightly	mildly	moder-ately	quite a bit	very much
50	overall a good student fast	0	1	2	3	4
51	overall a poor student slow learner	0	1	2	3	4
52	slow in learning to read	0	1	2	3	4
53	slow reader	0	1	2	3	4
54	trouble reversing letters	0	1	2	3	4
55	problems with spelling	0	1	2	3	4
56	trouble with mathematics or numbers	0	1	2	3	4
57	bad handwriting	0	1	2	3	4
58	able to read pretty well but never really enjoyed reading	0	1	2	3	4
59	not achieving up to potential	0	1	2	3	4
60	repeating grades	0	1	2	3	4
61	suspended or expelled	0	1	2	3	4

The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)

1. **Have you felt you ought to cut down on your drinking or drug use?**
2. **Have people annoyed you by criticizing your drinking or drug use?**
3. **Have you felt bad or guilty about your drinking or drug use?**
4. **Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?**

Score: __ /4

2/4 or greater = positive CAGE, further evaluation is indicated

Source: **Reprinted with permission from the *Wisconsin Medical Journal.* Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.**

Medical Review of Systems

Check next to any symptoms you have experienced since last visit/recently, or for which you have concerns about.

Name:______________________________

Date:______________________________

BP______/______ **p**______ **Ht**______ **Wt**______

	General
	Recent unexpected weight loss
	Chronic fatigue
	Anemia
	Lack of regular exercise
	Overweight

	Eyes
	Failing vision
	Eye pain
	Double vision
	Blurred vision
	Frequent eye infections
	Glaucoma
	Cataracts

	Ears, Nose, Mouth
	Decreased hearing
	Ringing in ears
	Frequent ear infections
	Frequent nose bleeds
	Sinus trouble
	Frequent sore throat
	Prolonged hoarseness
	Tooth or jaw pain

	Cardiovascular
	Chest pain
	Dizzy spells
	Fainting spells
	High blood pressure
	Swollen ankles
	Irregular pulse
	Shortness of breath

	Pulmonary
	Pneumonia/pleurisy
	Bronchitis/chronic cough
	Asthma/wheezing

	Gastrointestinal
	Recent loss of appetite
	Difficulty swallowing
	Heartburn/gastritis
	Persistent nausea/vomiting
	Chronic abdominal pain
	Gall bladder trouble
	Jaundice
	Change in appearance of stool
	Diarrhea
	Constipation
	Bloody or very dark stools
	Hemorrhoids
	Hernia

	Genito-Urinary
	Frequent urine infections
	Blood in urine
	Kidney stones
	Painful urination
	Loss of control of urine
	Decrease in flow
	Urination more than 2x per night
	Any venereal disease in the past? (Herpes, Chlamydia, Gonorrhea)

	Musculoskeletal
	Pain in joints
	Pain in muscles
	Recurrent back pains
	Past injury to bones, spine, or joints
	Gout attacks in the past
	Concerned about osteoporosis

	Integumentary
	Skin rashes
	Hives
	Skin moles – black or changing
	Breast mass
	Nipple discharge

	Neurologic
	Frequent headaches
	Tremor/hand shaking
	Muscle weakness
	Numbness/tingling
	Seizures/convulsions
	Difficulty sleeping
	Excessive daytime sleeping
	Memory loss

	Psychological
	Feeling depressed
	Nervous or anxious feeling
	Excessive moodiness
	Difficulty concentrating
	Phobias/unexplained fears
	Loss of pleasure in life

	Endocrine
	Excessive thirst and urination
	Feet and hands numbness/pain
	Low blood sugar problems
	Intolerance to heat or cold

	Hematologic/Lymphatic
	Excessive bruising
	Swollen glands in neck, armpit, or groin
	Unexplained fever, chills, night sweats

	Allergic/Immunologic
	Hay fever/allergies
	Acquiring many infections
	Desire HIV discussion

	Substance/Chemical Use
	More than 6 drinks a week
	Tobacco use
	Caffeine use
	Over-the-counter meds/vitamins

	Women only
	Irregular periods
	Excessive flow/pain
	Hot flashes/night sweats
	Abnormal PAP smear

Anything else you want your doctor to be aware of?