Special Diagnostic Services
Telephone: (404) 778-0990
Fax: (404) 778-0980

INITIAL DIAGNOSTIC SERVICES PROFILE

MRN #: ____________________________
Per Diagnostic Staff

DEMOGRAPHICS

Name: ___________________________, ______________________, _____
(Last) (First) (M.I.)

Age: _________ E-mail address: ____

Cell Number___________________________ Home/Business Number_________________________________

Date of Birth: ___/_____/____ M _______ F______ Appointment Date: ________/_____/_____

Appointment with Dr. _______________________ Occupation: ______________________________________

Pharmacy Information: Name of your preferred pharmacy: ____

Pharmacy Address: ____

Pharmacy Phone: (_____) - _________________ Pharmacy Fax: (_____) - ___________________

Personal Physician: (Name & Address)

____

____

____

Phone: (_____) _______-________________

Fax: (_____) _______-________________

Please sign below if you would like copies of your reports sent to your Primary Physician to update his/her files.

Signature: ______________________________________ **Date:** _______/_____/__________

Revision Date 08/11/14

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PAST MEDICAL HISTORY -

Please list any problems which you have, or have had in the past. Indicate year of onset.

PROBLEM	ONSET
(1) ______________________	________
(2) ______________________	________
(3) ______________________	________
(4) ______________________	________
(5) ______________________	________
(6) ______________________	________
(7) ______________________	________
(8) ______________________	________

Past Emotional Mental/Health History

Please list any mental health problems which you have, or have had in the past. Indicate year of onse

PROBLEM	ONSET
1 ______________________	________
2 ______________________	________

Yes **NO** Have you ever experienced major psychological trauma such as physical, sexual, or emotional abuse, victimization, combat, or witnessed trauma?

PREVIOUS SURGERY -

Please list any procedures you have had. Also indicate the date the procedure was performed.

PROCEDURE	DATE
(1) ______________________	________
(2) ______________________	________
(3) ______________________	________
(4) ______________________	________
(5) ______________________	________

Please list your Diagnostic Concerns

1.) ______________ 2.)______________ 3.)______________

4.)______________ 5.)______________ 6.)______________

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HEALTH MAINTENANCE

Please indicate which screening procedures (if any) that you have had.

Procedure	Date	Comments
None ☐		
Pap Smear		
Mammogram		
Bone Density		
Prostate Surface Antigen (PSA) test		
Colonoscopy		
Treadmill Stress Test		
CT Heart Cardiac Scoring/Calcium Scoring		
CT Lung		
Other		

CURRENT MEDICATIONS

Prescription	Dose	Frequency	Reason Taking	Year Begun
None ☐				
Over the Counter, including Supplements, Herbal Products, and Vitamins	**Dose**	**Frequency**	**Reason Taking**	**Year Begun**
None ☐				

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MEDICATION ALLERGIES

Medication	Year of Reaction	Reaction
None ☐		

IMMUNIZATIONS

Vaccination	Date last given	Vaccination	Date last given
Tetanus (DPT)		Chicken Pox (Varicella)	
Tetanus Pertussis (Tdap)		Gardisil (HPV)	
Pneumovax (pneumonia)		Hepatitis A	
MMR		Hepatitis B	
Influenza		Yellow Fever	
Measles		International Travel Planning	
Shingles			

FAMILY MEDICAL HISTORY

Name	Age (Or age died)		Living/ Dead	Health Issue or Cause of Death/Comments
PARENTS				
Father:				
Mother:				
Gradparents				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
SPOUSE				
Name:				
SIBLINGS	**Sex**	**Age**		
1.				
2.				
3.				
4.				
5.				
CHILDREN	**Sex**	**Age**		
1.				
2.				
3.				
4.				
5.				

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LIFESTYLE FACTORS

1. **Cigarette Use**

a. Current smoker ________ Past smoker ________ Year quit ________ Never smoked ________

b. Average number of packs per day: _______ c. Total number of years smoked: ________

2. **Other Tobacco Use**

a. None ________ Current user ________ Past user ________ Year quit________________

b. Pipe ________ Cigar ________ Smokeless ________ Number of years used: ______________

c. Electronic Cigarette ________

3. **Alcohol Use**

a. Average number of drinks per WEEK:
(One "drink" equals: 1 1/2 oz. liquor, 4 oz. wine, 12 oz. beer)

0-2:_______ 3-5: _______ 6-10: _______ 11-15: _______ 16-20: _______ 21-25: _______ 26+:_______

b. Drank in past but quit________ (Year quit________) Never drank__________

4. **Sleep:** Average number of hours per NIGHT: ______________

5. **International travel in last two years:** Date(s) ______________

Location(s)____

SOCIAL HISTORY

1. **Marital Status:**
a. Currently married? Yes No Years married: _______ Spouse's Name: ______________

b. Number times married: _______ Divorced: ________ Number of children: ________

2. **Education:**

College Graduate: Yes No Year _____

Graduate Degree: ____________________ Year _____

If no, highest grade achieved: ____________________

3. **City and State of birth** ____________________

4.Previous Lyme Test Yes No If yes, number of tests________ If you have had previous Lyme test(s) number of positive Lyme tests________

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REVIEW OF SYSTEMS

Please check yes or no to each of the following symptoms which apply. If unsure, leave blank.

No	Yes	Constitutional	Comments
		Fever	
		Chills	
		Night Sweats	
		Weakness	
		Fatigue	
		Flushing	
		Decreased Activity	
		Unexplained Weight Gain/Loss	
		Eye	
		Recent Visual Problem	
		Yellow eyes	
		Infection/Eye Discharge	
		Blurring	
		Double Vision	
		Visual Disturbances	
		Glasses	
		Contacts	
		ENT	
		Decreased Hearing	
		Ear Pain	
		Nasal Congestion	
		Sore Throat	
		Ringing in ears	
		Allergies (Hay Fever)	
		Hoarseness	
		Mouth Ulcers	
		Respiratory	
		Shortness of breath	
		Cough	
		Sputum production	
		Wheezing	
		Cyanosis	
		Snoring	
		Sleep Apnea	
		Pneumonia	
		Caughing up Blood	
		Use of CPAP machine	
		Daytime sleepiness	
		Cardiovascular	
		Chest pain	
		Palpitations	
		History of pace make placement	
		Claudication (pain in legs with walking)	
		Peripheral Edema (swelling in legs)	
		Syncope	
		Chest pain/pressure with exertion	
		Heart Murmur	
		Heart Cath	
		Stent Placement	

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No	Yes	Breasts	Comments
		Fibrocystic disease	
		Lump/Mass	
		Nipple discharge	
		Abnormal mammogram in past	Date (M/Y) _______
		Previous breast biopsy (right/left)	
		Gastrointestinal	
		Trouble swallowing/food sticking	
		Nausea	
		Vomiting	
		Diarrhea	
		Constipation	
		Heartburn	
		Ulcers	
		Abdominal pain	
		Pain or discomfort after eating	
		Red blood in stools	
		Black tarry stools	
		Hemorrhoids	
		Throwing up blood	
		Urinary	
		Urinary tract infections	
		Pain/Burning with urination	
		Trouble starting flow	
		Trouble stopping flow	
		Leaking or incontinence	
		Kidney stones	
		Waking at night to urinate	
		Blood in urine	
		Kidney problems	
		Male Genito-Urinary	
		History of sexually transmitted infection	
		Penile discharge	
		Pain/burning with urination	
		Pain in testicles	
		Lumps in testicles or scrotum	
		Significantly decreased sexual desire	
		Decreased ability to achieve erection	
		Female Genito-Urinary	
		Last menstural period	
		Post menopausal hormone use	
		Excessive menstrual bleeding	
		Post menopausal bleeding	
		Bleeding between periods	
		Previous abnormal pap smear	
		Frequent yeast infections	
		Sexually Transmitted Diseases	
		Pain with intercourse	
		Bleeding after intecourse	
		Hot flashes	

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		Infertility problems	
		Pregnancy induced hypertension	
		Preeclampsia	
		Gestational diabetes	
		Last Menstrual Period	
		Number of pregnancies	
		Number of live births	
		Number of miscarriages	
		Hematology/Lymph	**Comments**
		Bruising Tendency	
		Bleeding tendency	
		Bruise	
		Hemorrhage	
		Petichiae	
		Swollen Lymph Glands	
		Endocrine	
		Excessive thirst	
		Excessive urination	
		Cold intolerance	
		Heat intolerance	
		Excessive Hunger	
		Tremulousness	
		Increased body/facial hair	
		Thyroid problems	
		History of diabetes	
		Immunologic	
		Prior chemotherapy	
		Prolonged steroid use	
		immunocompromised	
		Frequent Infections	
		Musculoskeletal	
		Back pain	
		Neck pain	
		significant joint pains/arthritis	
		unusual muscle pain	
		significant prior trauma	
		sciatica	
		Skin	
		Rash	
		Itching	
		Previous skin cancer	
		Pre-Cancerous skin lesions	
		Change in skin color	
		Changing moles	
		Unsual Loss of hair	
		Changes in nails	
		Excessive dry skin	
		Neurologic	
		Abnormal balance/coordination	
		Spells of confusion	
		Numbness	
		Tingling	
		Headaches	
		Weakness of leg	
		Weakness of arm	
		Frequent dizziness	
		Trouble with speech	
		Seizures	

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No	Yes	Psychiatric	Comments
		Anxiety	
		Depression	
		Mania	
		Suicidal	
		Delusional	
		Hallucinations	
		Alcohol Abuse	

1.) **Have you had to quit working because of this illness?** **YES___** **NO____** **Other____**

2.) **Have you had to cut back the number of hours you work due to this illness?** **YES___** **NO____** **Other____**

3.) **Have felt it necessary to apply for disability benefits due to this illness?** **YES___** **NO____** **Other____**

4.) **Are you receiving disability benefits because of this illness?** **YES____** **NO____** **Other____**

5.) **Has this illness affected your professional or family well being?** **YES____** **NO____** **Other____**

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Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF)

Taking everything into consideration, during the past week how satisfied have you been with your………

	Very Poor	Poor	Fair	Good	Very Good
….physical health?	1	2	3	4	5
….mood?	1	2	3	4	5
….work?	1	2	3	4	5
…household activities?	1	2	3	4	5
….social relationships?	1	2	3	4	5
….family relationships?	1	2	3	4	5
….leisure time activities?	1	2	3	4	5
…ability to function in daily life?	1	2	3	4	5
…sexual drive, interest and/or performance? (If very poor, poor or fair underline the factor why)	1	2	3	4	5
…economic status?	1	2	3	4	5
…living/housing situation? (if very poor, poor or fair underline the factor why)	1	2	3	4	5
…ability to get around physically without feeling dizzy or unsteady or falling? (if very poor, poor or fair underline the factor why)	1	2	3	4	5
…your vision in terms of ability to do work or hobbies? (if very poor, poor or fair underline the factor why)	1	2	3	4	5
…overall sense of well being?	1	2	3	4	5
…medication? (If not taking any, check here____ and leave item blank)	1	2	3	4	5
…How would you rate your overall life satisfaction and contentment during the past week?	1	2	3	4	5

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Work and Social Adjustment Scale (W&SAS)

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

1.) ***work*** *– if you are retired or choose not to have a job for reasons unrelated to your problem, please tick here*

0 1 2 3 4 5 6 7 8

not at all *slightly* *definitely* *markedly* *very severely I cannot work*

2.) ***home management*** – cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc

0 1 2 3 4 5 6 7 8

not at all *slightly* *definitely* *markedly* *very severely*

3.) ***social leisure activities*** – with other people, e.g. parties, pubs, outings, entertaining etc

0 1 2 3 4 5 6 7 8

not at all *slightly* *definitely* *markedly* *very severely*

4.) ***private leisure activities*** – done alone, e.g. reading, gardening, sewing, hobbies, walking etc

0 1 2 3 4 5 6 7 8

not at all *slightly* *definitely* *markedly* *very severely*

5.) ***family and relationships*** – form and maintain close relationships with others including the people that I live with

0 1 2 3 4 5 6 7 8

not at all *slightly* *definitely* *markedly* *very severely*

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________ **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 fidgety 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 in some way	0	1	2	3
add columns:			+	+
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	______

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at *http://www.pfizer.com*. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.