Dunkirk Family Practice, PA
Dr. Catherine Brophy
Dr. David Denekas
Dr. Joyce Owens

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

**Primary Care Provider's Name: _____**

**If someone at home helps you with your health care:**

**Caregiver Name: _____ Phone number: _____**

**Email Address: _____**

**How do you know this person? (For example, is this your sister, your father, or your friend?)**

**_____**

**If you see any other doctors, case managers or care providers, who else is on your care team?**

| Name | They help take care of my: | Contact Number | When to call this Team Member | Next Appointment |
|---|---|---|---|---|
| | | | | |
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| | | | | |
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**We would like to get to know you better.**

The language you are most comfortable speaking is: _____.

Name:

You like to communicate about important things by: (please circle) talking on the telephone/sending and receiving text messages/using email/receiving regular post office mail.

Your cell phone number: _____

Your email address: _____

**Your Health History** (Medical Conditions, things you are worried about, or barriers or issues that could keep you from reaching your health goals)**:**

| | |
|---|---|
| 1. | 8. |
| 2. | 9. |
| 3. | 10. |
| 4. | 11. |
| 5. | 12. |
| 6. | 13. |
| 7. | 14. |

**Health Problems Experienced by your Family Members (Please list):**

| **Your Mother:** | **Your Father:** | **Your Siblings:** | **Your Children:** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Do you smoke (Circle one)?**

- No, never. - Yes. (How many cigarettes and how often? _____)

- I used to smoke. (When did you quit? _____ How much did you used to smoke, and for how long? _____)

**How many alcoholic beverages do you drink in a typical day? _____**

Name:

# Health Risk Assessment

**How many alcoholic beverages do you drink in a typical week? _____**

**If you do drink alcohol, what kind of alcohol do you drink?**

_____

**How healthy do you feel today? (Circle all that apply):**

I feel well today. I feel my health is getting better.

I feel my health is getting worse.

I feel unwell today. I am having these problems:

_____

_____

**Additional Medications:**
If you are taking any new medicines since your primary doctor last saw you, please list them here:

_____

_____

**On a normal day, I need some help with the following things (circle any that apply):**

- Feeding myself
- Showering or bathing
- Using the toilet
- Getting dressed
- Brushing my hair
- Walking or moving from one place to another
- Managing my finances
- Shopping

Name:

- Preparing meals
- Using the telephone
- Managing my medications
- Doing basic housework
- Handling transportation (driving or navigating public transit)

**Have you fallen in the past 12 months? (Circle one):** Yes No

**Are you worried about falling in the next 6 months? (Circle one):** Yes No

**Do any of the following Health Risks apply to you? (Circle all that apply):**

| | |
|---|---|
| Feelings of anxiety or depression | Increased stress |
| Trouble with my memory | Social Isolation |
| Second Hand Smoke | Inability to take medications (cannot afford or does not remember) |
| Physical inactivity | Poor nutrition, lack of balanced diet |
| Inadequate nutrition or access to food | Illegal drug use |

**Over the past two weeks, have you felt anxious, down or depressed? (Circle one):** Yes No

**Over the past two weeks, have you experienced little interest or pleasure in doing things? (Circle one):** Yes No

**Do you have any concerns with your vision? (Circle one):** Yes No

**Do you have any concerns with your hearing? (Circle one):** Yes No

**Do you have any concerns with your safety at home? (Circle one):** Yes No

Name:

# Health Risk Assessment

**Have you made an Advanced Directive, including the following? :**

- **Living Will? (Circle One):** Yes No

- **Durable Medical Power of Attorney/Healthcare Proxy? (Circle One):**
  Yes No

**If there is anything else you would like to discuss with your doctor today, please list here:**

_____

_____

_____

_____

Patient Signature: _____Date: _____

Patient Name (Printed): _____