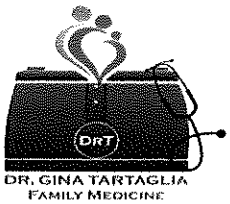


225 Veterans Road, Suite 202
Yorktown Heights, NY 10591

Healthcare Maintenance Form

Name: _____

Exams and Screenings – Please complete to the best of your knowledge.

Last Physical Exam: _____/_____

*If your last physical was not with our office:

Name of Healthcare Provider: _____

Name of Facility: _____

Last Eye Exam: _____/_____

Please circle how often you are seen: 3 months / 6 months / annually Other: _____

Last Dental Exam: _____/_____

Name of Facility: _____

Last Colonoscopy: _____/_____ I have not done this test: □

Name of Facility: _____

Next recommended exam: _____

Last Exercise Stress Test: _____/_____ I have not done this test: □

Name of Healthcare Provider: _____

Name of Facility: _____

Last Mammography (and sonogram): _____/_____ I have not done this test: □

Name of Facility: _____

Next recommended exam: _____

***For Females only**

Last Pap smear Exam: _____/_____ I have not done this test: □

Please circle how often you are seen: 3 months / 6 months / annually Other: _____

Last Bone Density Exam: _____/_____ I have not done this test: □

Name of Facility: _____

Specialists' – Please fill out information, **in full**, of all other providers you see regularly or on an annual basis.

Type	Name of Provider	Last appt. (Date)	Follow-up (Date)	Name of Facility
Allergist				
Audiologist				
Breast Surgeon				
Cardiologist				
Dentist				
Dermatologist				
ENT				
Endocrinologist				
Gastroenterologist				
Genetics				
GI Surgeon				
OB/GYN				
Hematologist				
Hepatologist				
Nephrologist				
Neuro-Ophtho				
Neuro Surgeon				
Oncologist				
Orthopedic				
Pain Management				
Physiatrist/Rehab				
Podiatrist				
Psychiatrist				
Pulmonologist				
Rheumatologist				
Surgeon				
Urologist				
Vascular Surgeon				
Other				

Immunizations – Please complete to the best of your knowledge.

TDap (Tetanus/Whooping cough): _____ (Year of last immunization – should be within the last 10 years)

COVID-19

Moderna: ___/___/____ and ___/___/____

Pfizer: ___/___/____ and ___/___/____

J & J: ___/___/____

1st Booster: Mod./Pfiz./J&J ___/___/____

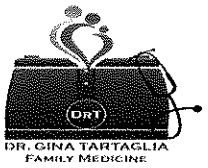
2nd Booster: Mod./Pfiz./J&J ___/___/____

Influenza (Flu): _____ (Month/Year)

Shingles: ___/___/____ and ___/___/____

Pneumonia: *For ages 65+ years, Pneumonia recommended every 5 years

Facility administered: _____ Date: _____



225 Veterans Rod, Suite 202
Yorktown Heights, NY 10598

Smoking and Tobacco Screening

Name: _____ **Date:** _____

I do not smoke: □

I am a former smoker: □ Year started: _____ Year quit: _____

Please circle the following: I was a light / moderate / heavy smoker.

I am a current smoker: □ Year started: _____

Please circle the following: I am a light / moderate/heavy smoker.

Do you chew tobacco, smoke cigarettes, or use e-cigarettes (vape)? Yes No

If yes, how many cigarettes do you smoke per day? _____/Day or _____/Packs

Have you tried to quit? Yes No

If yes, what have you done to quit?

_____

Are you aware of the medical problems that are related to smoking? Yes No

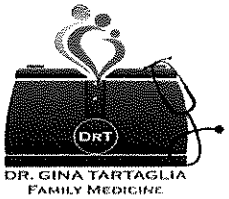
Are you interested in trying to quit? Yes No

Do you live with a smoker? Yes No

Have you ever had a chest X-ray or CT scan of your chest to screen for lung cancer? Yes No

Reviewed by: _____

Date: _____



225 Veterans Road, Suite 202
Yorktown Heights, NY 10591

Alcohol Screening

Name: _____ **Date:** _____

I do not drink alcohol: □

How often do you have a drinking containing alcohol? _____

When you drink alcohol, how many drinks do you have in a day? _____

Do you find it hard to stop drinking once you started? _____

Does drinking interfere with your life? _____

Do you have a drink when you first wake up in the morning? _____

Do you ever feel guilty about your drinking? _____

Do you ever forget things or black out because of your drinking? _____

Have you injured yourself or someone else because of drinking? _____

Has anyone ever suggested you cut back or stop drinking? _____

Reviewed by: _____

Date: _____

Hereditary Cancer Syndrome Risk Assessment

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

This is a screening tool for the common features of Hereditary Breast and Ovarian Cancer Syndrome and Lynch Syndrome.

Instruction:

- Please circle **Y** for those that apply to **YOU and/or YOUR FAMILY** (on both your mothers or fathers side).
- Each statement should be answered individually, so you may list the same cancer diagnosis more than once.
- You and the following family member should be considered:

Mother, Father, Brother, Sister, Children, Nieces/Nephews
Maternal – Grandmother, Grandfather, Aunts, Uncles, First Cousins
Paternal - Grandmother, Grandfather, Aunts, Uncles, First Cousins

Y	N	Have you ever been tested for hereditary risk of cancer (BRCA testing or Lynch Syndrome Testing)? If yes, please explain:			
Y	N	Have any members of your family ever been tested for hereditary risk of cancer (BRCA testing or Lynch Syndrome Testing)? If yes, please explain:			
		BREAST AND OVARIAN CANCER	**SELF**	**FAMILY MEMBER**	**AGE AT DIAGNOSIS**
Y	N	Ashkenazi Jewish ancestry with breast or ovarian cancer diagnosed in you or any family member?			
Y	N	Ovarian cancer diagnosed in you or any family members?			
Y	N	Male breast cancer diagnosed in any family members?			
Y	N	Breast cancer diagnosed at 45 years of age or younger in you or any family members?			
Y	N	Bilateral breast cancer or multiple primary breast cancers diagnosed in you or any family members?			
Y	N	Three or more breast cancers diagnosed all on the same side of your family?			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family?			
		COLON AND UTERINE CANCER	**SELF**	**FAMILY MEMBER**	**AGE AT DIAGNOSIS**
Y	N	Colon cancer diagnosed before 50 years of age in you or any family members?			
Y	N	Uterine (Endometrial) cancer diagnosed before 50 years of age in you or any family members?			
Y	N	Two or more of the following cancers diagnosed all on the same side of your family(colon, uterine, ovarian, stomach, small Bowel, kidney/urinary tract, pancreatic, or brain)			

For Office Use Only

Patient offered genetic testing

☐ Accepted ☐ Declined Reviewed By: _____

Patient Signature _____

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 _____

A2663B 10-04-2005

Patient Name:	Date of Birth:	Date of Visit:

Allergy and Asthma Screening

Have you suffered from these symptoms in the last 6-12 months?

OItchy eyes	OStuffy nose	OSneezing
OWatery eyes	ORunny nose	OScratchy/sore throat

Additional symptoms: _____

Are your symptoms seasonal? OYes ONo

Do you have sneezing fits? OYes ONo

Do you get sinus infections, frequent colds, flu, runny nose, or congestion? OYes ONo

Do antihistamines such as Benadryl, Allegra, Claritin, Zyrtec relieve your symptoms? OYes ONo

Have you been diagnosed with asthma? OYes ONo

Do you have an inhaler? OYes ONo

If you have a rescue inhaler, how often do you use it? _____

Have you ever had a life-threatening allergy reaction? OYes ONo

When? _____

What caused it? _____

For office use only:

Allergy Test: **ONot Needed** **ODeclined** **OScheduled**

Provider signature_____

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	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 any problems, how difficult have they 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
☐	☐	☐	☐

Source: 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 ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

Exercise is Medicine®

AMERICAN COLLEGE of SPORTS MEDICINE®

Name: _____ Date: _____

2018 Physical Activity Guidelines for Adults:

- 150-300 minutes/week of moderate-intensity activity or 75 minutes/week of vigorous activity (somewhat hard to very hard) or a combination of both
- Muscle strength training 2 or more times a week

❑ Aerobic Activity *(circle)*

Frequency (days/week): 1 2 3 4 5 6 7

Intensity: Light (casual walk) Moderate (brisk walk) Vigorous (like jogging)

Time (minutes/day): 10 20 30 40 50 60 or more

Type: Walk Run Bike Swim/Water Exercise
Other _____

Steps/day: 2,500 5,000 7,500 10,000 or more
Other _____

❑ Muscle Strength Training *(circle)*

Frequency (days/week): 1 2 3 4 5 6 7

Prescriber's Signature:

What about aerobic activity?

- Moderate activity is at a pace where you can talk but cannot "sing." Examples: *brisk walking, light biking, water exercise,* and *dancing.*
- Vigorous activity is done at a pace where you can't say more than a few words without pausing for a breath. Examples: *jogging, swimming, tennis,* and *fast bicycling.*
- You can exercise for any length of time. For example, you might walk,
  - 30 minutes 5 days/week or
  - 20 minutes daily
  - 5 minutes here, 10 minutes there. Just work your way up to 150 total minutes/week.
- Gradually build up to a daily step count of 7,500-10,000 steps/day.

What about strength training?

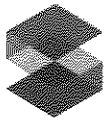
- You don't have to go to a gym. You can use elastic bands, do body weight exercises (kitchen counter push-ups, chair sit-to-stands), or lift dumbbells. Heavy work around your home also builds strength.
- Strengthen your legs, back, chest, and arms. To start, try 10-15 repetitions using light effort. Build up to medium or hard effort for 8-12 repetitions. Repeat 2-4 times, 2-3 days/week.
- Give yourself a rest day between each strength training session.

How will you get started **this week?**

NUTRITION SCREENER

When answering these questions, think about your typical days and weeks.
Be as honest and accurate as possible – this will help us provide you the best nutrition advice for you!

Over the past few months:			
1. How often did you eat fruit? (consider fresh, frozen, canned, and dried options and 100% juice)	0-2 times/week ○	3-5 times/week ○	6+ times/week ○
2. How often did you eat vegetables? (consider fresh, frozen, canned, and dried options and 100% juice)	0-2 times/week ○	3-6 times/week ○	7+ times/week ○
3. How often did you eat dark green, red, and/or orange vegetables?	0-2 times/week ○	3-4 times/week ○	5+ times/week ○
4. How often did you eat beans, peas, and/or lentils?	0 times/week ○	1-2 times/week ○	3+ times/week ○
5. How often did you consume red or processed meat (like hot dogs, sausages, ham, or lunch meats)?	5+ times/week ○	3-4 times/week ○	0-2 times/week ○
6. How often did you consume fish or shellfish?	0 times/week ○	1-2 times/week ○	3+ times/week ○
7. How often did you consume nuts, seeds, and/or soy products (like tofu, tempeh, or soybeans/edamame)?	0-1 times/week ○	2-3 times/week ○	4+ times/week ○
8. How often did you eat or use butter, spreads, fried foods, and/or full-fat dairy products (like cheese, whole milk, yogurt, ice cream, or cream cheese) in meals or snacks?	8+ times/week ○	4-7 times/week ○	0-3 times/week ○
9. How often did you eat whole grains? (like whole-wheat bread and pasta, whole-wheat or corn tortillas, oatmeal, or brown rice)	0-1 times/week ○	2-3 times/week ○	4+ times/week ○
10. How often did you consume sweets (like donuts, cookies, cake, pies, or candy)?	4+ times/week ○	2-3 times/week ○	0-1 times/week ○
11. How often did you drink sugar sweetened beverages (like soda, sweetened coffee drinks, energy drinks, or sweet tea)?	4+ times/week ○	2-3 times/week ○	0-1 times/week ○
12. How often did you drink alcoholic beverages?	7+ beverages/week ○	4-6 beverages/week ○	0-3 beverages/week ○
13. How often did you eat away from home at fast food or sit-down restaurants?	5+ times/week ○	2-4 times/week ○	0-1 times/week ○
14. How many days/week did you get at least 30 minutes of moderate to strenuous physical activity with enough movement to break a light sweat (like brisk walking, biking, swimming)?	0-1 time/week ○	2-4 times/week ○	5+ times/week ○



SignatureMD