Internal Medicine & Aesthetics
Of The Rockies

Munni Selagamsetty M.D, Stephanie DeAvila NP, Tayler Green NP, Erin Grudle NP, Elizabeth Cruz NP
2875 International Circle Colorado Springs, CO 80910
Phone: 719.389.0070 Fax: 719.389.0071

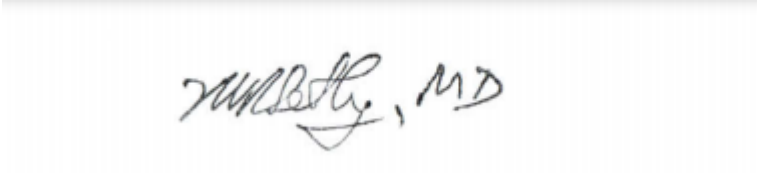
Dear Valued Patient,

We strive to provide exceptional care to all of our patients. Please fill out the attached paperwork as mandated by insurance prior to your annual exam. Whether you are an established or new patient, it is necessary to fill this out to help us provide safe, effective care.

(There is usually no co-pay for this type of visit. However, if there is a need for any additional services, or if a new condition is addressed, a copay or coinsurance may apply.)

Thank you for trusting us with your care. We look forward to seeing you.

Sincerely,
Munni Selegamsetty, M.D.



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PATIENT INFORMATION

Patient Name: (Last)_____ **(First)**_____**(MI)**_____

Preferred Name: _____ **Sex: M / F**

Date Of Birth:_____ **Martial Status: (Circle One) S M DW Separated**

Street Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone:_____**Work Phone:**_____**Cell Phone:**_____

SSN#:_____**Email Address:**_____

Employer:_____ **Address:**_____**Phone#:**_____

Name of Spouse:_____**Relationship:**_____**Phone#**_____

Address:_____**City:**_____**Zip Code:**____

Employer:_____

EMERGENCY CONTACT(S)

Name:_____**Relationship:**_____**Phone#**_____

Name:_____**Relationship:**_____**Phone#**_____

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SOCIAL HISTORY

EXERCISE – TYPE:_____ **AMOUNT PER DAY/WEEK:**_____

BEVERAGES AMOUNT PER DAY/WEEK: ALCOHOL____ TEA____ COFFEE___

SMOKING: TABACCO___(PACK__ STICKS___) MARIJUANA__ OTHER SUBSTANCE_____

CURRENT: HOW LONG_____(YEARS)

QUIT: WHEN_____ HOW MANY YEARS_____

NEW FAMILY HEALTH HISTORY: ☐ *No new family history reported since the last annual visit.*

Name	Relationship	Medical Condition	Age of Onset	Deceased	Age of Death
				☐ Y ☐ N	
				☐ Y ☐ N	
				☐ Y ☐ N	
				☐ Y ☐ N	
				☐ Y ☐ N	
				☐ Y ☐ N	
				☐ Y ☐ N	
				☐ Y ☐ N	
				☐ Y ☐ N	
				☐ Y ☐ N	

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HEALTH MAINTENANCE

EYE EXAM	**DATE:**
DENTAL EXAM:	**DATE:**
SKIN EXAM:	**DATE:**

NEW SURGICAL HISTORY ☐*No new surgical history since the last annual visit.*

TYPE	**DATE:**

NEW HOSPITALIZATION HISTORY ☐*No new hospital history since the last annual visit.*

DATE:	**REASON:**

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FEMALE ONLY

MENSTRUAL HISTORY

AGE OF ONSET_____

☐REGULAR

☐IRREGULAR

OBSTERICAL HISTORY

NUMBER OF PREGNANCIES_____

NUMBER OF LIVE BIRTHS_____

NUMBER OF MISCARRIAGES_____

NUMBER OF ABORTIONS_____

TYPE OF BIRTH CONTROL USED_____

FLOW

☐HEAVY

☐MODERATE

☐LIGHT

DAYS OF FLOW_____

LENGTH OF FLOW_____

PMS_____

CRAMPS/PAIN WITH CYCLE_____

DATE OF LAST PAP_____

☐NORMAL

☐ABNORMAL

CONE BIOPSY_____

DYSPLASIA_____

CLASS II – IV PAP _____

ENDOMETRIAL BIOPSY_____

LAST MAMMOGRAM_____

HISTORY OF FAMILY BREAST CANCER_____

YEAST INFECTIONS_____

MENOPAUSAL SYMPTOMS

AGE OF ONSET_____

HORMONES MEDICATION_____

☐HOT FLASHES

☐MOOD SWINGS

☐IRRIABILITY

☐DEPRESSION

MISCELLANEOUS

PAIN WITH INTERCOURSE_____

☐ABNORMAL BLEEDING

☐ENDOMETROSIS

☐PELVIC INFLAMATORY DISEASE

SEXUALLLY TRANSMITTED DISEASE:

1._____

2._____

3._____

4._____

INTERNAL MEDICINE OF THE ROCKIES

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Patient Health Questionnaire **(PHQ-9)**

PATIENT NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems.
(Use a " √ " 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 the 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 a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or hurting yourself.	0	1	2	3
Add columns		+	+	+

(Healthcare professional: For Interpretation of Total, Please refer to the 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 people?	*N*ot difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficulty _____

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Patient Health Questionnaire **(GAD-7)**

PATIENT NAME: _____DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems.
(Use a " √ " to indicate your answer)

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
11. Feeling nervous, anxious, or on edge.	0	1	2	3
12. Not being able to stop or control worrying.	0	1	2	3
13. Worrying too much about different things.	0	1	2	3
14. Trouble relaxing	0	1	2	3
15. Being so restless that it's hard to sit still.	0	1	2	3
16. Becoming so easily annoyed or irritable.	0	1	2	3
17. Feeling afraid as if something awful might happen.	0	1	2	3
Add columns		+	+	+

(Healthcare professional: For Interpretation of Total, Please refer to the accompanying scoring card)

TOTAL _____

18. 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 people?

Not difficult at all _____

Somewhat difficult _____

Very difficulty _____

Extremely difficulty _____

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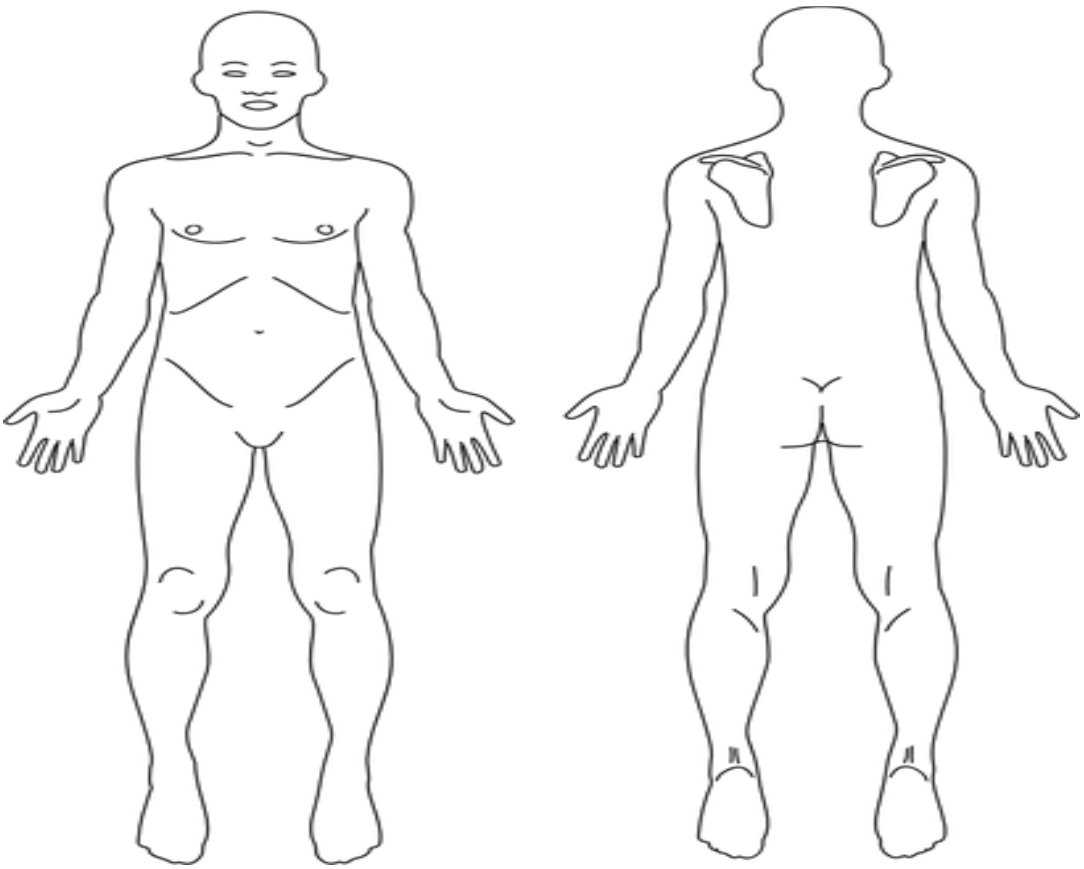
1. **Do you currently suffer from any type of pain? ____ Yes _____ No Where: _____**

2. **In the past 7 days, how much pain have you felt? _____None _____ Some _____ A lot**

3. **Describe the characteristics of the pain: ____Sharp ____Dull ____Burning _____Other(EXPLAIN)**

   What type of pain: ___Intermittent ____Variable (constant to intense "break-though"pain)
   _____Constant to stable intensity

4. **Please signify by circling the area where you experience the pain:**



5. **Pain Scale: Please mark which face shows your level of pain right now.**

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FALL RISK ASSESSMENT

Circle "YES" or "NO" for each statement below			Why it matters
YES	**NO**	I have fallen in the past year	People who have fallen once are likely to fall again
YES	**NO**	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall
YES	**NO**	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance
YES	**NO**	I steady myself by holding onto the furniture when walking home.	This is also a sign of poor balance
YES	**NO**	I am worried about falling.	People who are worried about falling are more likely to fall
YES	**NO**	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles
YES	**NO**	I have some trouble stepping up onto a curb.	This is a sign of weak leg muscles
YES	**NO**	I must often rush to the toilet.	Rushing to the bathroom, especially at night, increases your chances of falling.
YES	**NO**	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls
YES	**NO**	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling
YES	**NO**	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of fall
YES	**NO**	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls
TOTAL _____Add up the number of points for each "yes" answer. If you scored 4points or more, you may be at risk of falling			

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Health Risk Assessment (HRA) for Annual Physical Exam

Patient Name: _____ DOB: ____/____/____

Date: ____/____/___

The questions below are to help your provider assess your risks. Please answer every question.

1. In the past 7 days, how many days did you exercise: ____days

   On days that you do exercise, for how long did you exercise? (in minutes)

   ____Minutes per day ____Does Not Apply

2. In the last 30 days, have you used any form of tobacco? ____Yes ____No

   If you answered yes, would you be interested in quitting tobacco use in the next month?

   ____Yes ____No

3. Have you ever used a smokeless tobacco product? ___Yes ____No

4. In the past 7 days, how many days did you drink alcohol? ____days

5. On days that you have consumed alcohol, how often did you consume drinks on one occasion? ___never ___once during the week __2-3 times a week ___More than 3 times a week

6. In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 med piece of fruit 1 cup = the size of a baseball)

   Total servings per day _____

7. In the past 7 days, how many servings of fried or high-fat food did you typically eat each day? (Examples of fried foods-fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, or foods made with whole milk)
   Total Servings per day _____.
8. In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?
   ____sugar-sweetened beverages consumed per day.
9. Do you always fasten your seat belt when in a car? ___Yes ___No
10. During the past 2 weeks, how often have you felt nervous, anxious, or on edge?
    ___Almost all the time ___Most of the Time ___Some of the Time ___Rarely
11. In the past two weeks, how often were you un-able to stop worrying?
    ___Almost all the time ___Most of the Time ___Some of the Time ___Rarely
12. How often is stress a problem for you in handling such things as:
    -Your Health? - Your Finances? - Your Family or social relationship? -Your Work?
    ____Never or rarely ___Sometimes ____Often ____Always
13. How often do you get the social and emotional support that you need?
    ___Always ___Usually ___Sometimes ___Rarely ___Never

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Health Risk Assessment (HRA) for Annual Physical Exam

Patient Name: _____ DOB: ____/____/____

Date: ____/____/___

14. In general, would you say your health is: __Excellent __Very Good __Good __Fair __Poor
15. In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet? __Yes __No
16. In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your medications? __Yes __No
17. How many hours of sleep do you usually get each night get? ___Hours
18. Do you feel that you snore at night, or have been told you snore? __Yes __No
19. In the past 7 days, how often have you felt sleepy during the daytime?
    __Always __Usually __Sometimes __Rarely __ Never
20. Do you currently have an advance directive in place? __Yes __No

    If you have not filled one out before this appointment, you will see that it is attached for your review. Please review it with your family member/s, and your provider will go over it with you during your visit. If you have any questions your provider will be happy to answer them.

    If yes, we are asking our patients to provide a copy to have in your file at our office. Your provider may discuss your wishes during your appointment.
21. Do you take your blood pressure regularly at home? ___Yes ___No
    (If yes, please bring that log with you so we may make a copy for your file)
22. Do you use marijuana? ___Yes _____When? ____No
23. Do you use illicit drug uses? ____Yes _____When? _____No
24. Please list any other providers that you are currently receiving treatment from.

Current Providers and Suppliers	**Phone# (If known)**
Specialist	
Specialist	
Specialist	
Specialist	
Specialist	
Specialist	