OMS

Oldendorf Medical Services, PLLC
Mark Oldendorf, MD Richard Balsam,
RPA Michelle Gariepy RPA Cheryl Ernst, NP

Comprehensive History and Assessment

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

Welcome to our practice! Please fill out the **front and back** of this form so we can get to know you. This information is vital for us to provide you with a comprehensive plan for your medical care. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit:_____
Other concerns:_____
What are your health goals for the next year?_____
Where were you receiving care before?_____
Do you or a family member have a mental health problem that you would like to discuss? _____
Are you a single parent? _____ Are you employed? _____ Are you the care giver of a family member? _____

Depression Screening: In the past **2 weeks**, have you been bothered by:
Little interest or pleasure in doing things? Yes □ No □ Feeling down, depressed, or hopeless? Yes □ No □

Review of Symptoms: Please mark the box and/or circle any **persistent** symptoms you have had **in the past few months**. Read through every section and check "no problems" if none of the symptoms apply to you.

General
__ Unexplained weight loss/gain
__ Unexplained fatigue/weakness
__ Fall asleep during the day when sitting
__ Fever, chills
__ No problems

Skin
__ New or change in mole
__ Rash/itching
__ No problems

Breast
__ Beast lump/pain/nipple discharge
__ No problems

Ears/Nose/Throat
__ Nosebleeds, trouble swallowing
__ Frequent sore throat, hoarseness
__ Hearing loss/ringing in ears
__ No problems

Eyes
__ Change in vision/eye pain/redness
__ No problems

Cardiovascular
__ Chest pain/discomfort
__ Palpitations (fast or irregular heartbeat)
__ No problems

Respiratory
__ Cough/wheeze
__ Loud snoring/altered breathing during sleep
__ Short of breath with exertion
__ No problems

Gastrointestinal
__ Heartburn/reflux/indigestion
__ Blood or change in bowel movement
__ Constipation
__ No problems

Genitourinary
__ Leaking urine
__ Blood in urine
__ Nighttime urination increased frequency
__ Discharge: penis or vagina
__ Concern with sexual function
__ No problems

Musculoskeletal
__ Neck pain
__ Back pain
__ Muscle/joint pain
__ No problems

Endocrine
__ Heat or cold sensitivity
__ No problems

Hematologic/Lymphatic
__Swollen glands
__Easy bruising
__ No problems

Neurological
__ Headaches
__ Memory loss
__ Fainting
__ Dizziness
__ Numbness/tingling]
__ Unsteady gait
__ Frequent falls
__ No problems

Allergic/Immune
__ Hay fever/allergies
__ Frequent infections
__ No problems

Psychiatric
__ Anxiety/stress/irritability
__ Sleep problem
__ Lack of concentration
__ No problems

Women only
__ Pre-menstrual symptoms (bloating, cramps, irritability)
__ Problem with menstrual periods
__ Hot flashes/night sweats
__ No problems

Immunizations: Check off any vaccinations you have had. Add year, if known.
Tetanus (Td) ____ With Pertussis (T dap) ____ Varicella (Chicken Pox) shot or illness ____
Pneumovax (pneumonia) ____ Influenza (flu shot) ____ Hepatitis A ____ Hepatitis B ____ MMR ____
Meningitis ____Zostavax (shingles) ____ HPV ____

1365 Washington Avenue Suite 100
Albany, New York 12206
Office: (518) 435-1300 Fax: (518) 435-1397

OMS

Oldendorf Medical Services, PLLC
Mark Oldendorf, MD Richard Balsam,
RPA Michelle Gariepy RPA Cheryl Ernst, NP

Comprehensive History and Assessment

Allergies: (List any reactions you have had)

_____

_____

Medications: (List all medications including non-prescription)

_____

_____

_____

_____

Previous Surgeries, Tests and/or Illness: (Please provide information and results of care obtained at other facilities **including self-referred specialist**)_____

_____

_____

_____

Relative Medical History of Parent, Sibling or Children (ex: Diabetes, Heart Disease, Stroke):_____

_____

Family, Cultural, Social needs: _____

Communication needs: Do you require special accommodations for

Hearing Impairment: Yes ☐ No ☐ Visual Impairment: Yes ☐ No ☐

Please Describe: _____

Have you had a **Colonoscopy?** Yes ☐ No ☐ If yes, when? _____

Dexa Scan (bone density)? Yes ☐ No ☐ If yes, when? _____

Tobacco Use:

Smoke cigarettes? Yes ☐ No ☐ Never ☐

Prior Smoker Quit date: ____ Number of years smoked? ____

How many packs per day did you smoke? _____

Current smoker: Packs per day? _____ Number of years? ____

Alcohol Use:

Do you drink alcohol? Yes ☐ No ☐

Number of drinks per week:

Beer____ Wine____Liquor_

Exercise:

Do you exercise regularly? Yes ☐ No ☐

If yes, what kinds of exercises do you do? _____

Drug Use:

Do you use marijuana or recreational drugs? Yes ☐ No ☐

Have you ever used needles to inject drugs? Yes ☐ No ☐

Women's Health History:

Date of last mammogram: _____

Age you started menstruation: _____

Age you started menopause: _____

Date of last Pap smear: _____

Last Period: _____

Health Planning:

Do you have a Health Proxy: Yes ☐ No ☐ Do you have an Advance Directive: Yes ☐ No ☐

Do you have a Do Not Resuscitate (DNR): Yes ☐ No ☐

1365 Washington Avenue Suite 100
Albany, New York 12206
Office: (518) 435-1300 Fax: (518) 435-1397