Needham Wellesley Family Medicine PC

65 Walnut Street, Suite 420
Wellesley Hills, MA 02481
(781) 235-3444. FAX (781) 235-6888
www.needhamwellesleyfamilymedicine.com

Parul Desai, MD
American Board of Family Medicine

Leonard M. Finn, MD
American Board of Family Medicine

Bruce Tofias, MD
American Board of Internal Medicine

Andrew C. Young, DO
American Board of Family Medicine
American Osteopathic Board of Family Physicians

Hayley R. Geller, MSN, FNP—C
American Academy of Nurse Practitioners

Name:_____DOB:_____Date:_____

Review of Systems

Do you have any problems or questions in any of these areas? Please check specific items.
(We will identify all problems today. Complete discussion may take place at future visits.)

Any changes to your medications?_____

GENERAL
- Weight loss
- Weight gain
- Appetite
- Sleep
- Lightheadedness
- Spinning
- Off balance
- Falls
- Fever/chills/sweats

EYES
- Change in vision

EARS/NOSE/THROAT/MOUTH
- Hearing loss
- Ringing in ears
- Problem with teeth/gums
- Hay fever
- Allergies

CARDIOVASCULAR
- Chest pain/chest discomfort
- Leg pain with exercise
- Palpitations/irregular heartbeats
- Chest pressure with exertion
- Leg swelling

BREAST
- Breast Lump
- Breast discharge
- Breast pain

RESPIRATORY
- Cough
- Shortness of breath
- Wheezing
- Tuberculosis

GASTROINTESTINAL
- Difficulty chewing
- Difficulty swallowing
- Nausea
- Vomiting
- Indigestion
- Heartburn
- Stomach pain
- Constipation
- Diarrhea
- Blood in stool

MUSCULOSKELETAL
- Muscle pain
- Joint pain
- Back pain

GENITOURINARY
- Burning urine
- Leaking urine
- Frequent urine
- Urgent urination
- Sexually transmitted disease
- Sexual function question

MALE
- Sore or discharge from penis
- Lump, swelling or pain of testicle

FEMALE
- Vaginal discharge or sores
- Vaginal bleeding
- Painful periods
- Period or menstruation question
- Vaginal discomfort

SKIN
- Rash
- Mole change — color, size
- Irritation

NEUROLOGICAL
- Numbness
- Tingling
- Memory loss
- Loss of coordination
- Headache

Name:_____

Do you have any allergies? Yes No
If yes, please list._____
Are you now or have you recently been under the care of another health provider? Yes No
If yes, who?_____
Have you ever had a blood transfusion? Yes No
If yes, date:_____Location:_____

Preventive care is an important part of your healthcare. The following questions address your lifestyle and will assist you and your physician to implement healthy habits. The results of this questionnaire will be kept confidential. Please circle any items you would like to discuss further.

HEALTHY HABITS HISTORY

Do you now or have you ever smoked cigarettes? Yes No
If currently, how much and how often? _____
If you have quit, quit date: _____
Do you drink Alcohol? Yes No
If yes:
a) How often do you have a drink containing alcohol? _____
b) Have you ever needed to cut down? Yes No
c) Have you ever felt guilty about your drinking? Yes No
d) Have you ever had a drink in the morning? Yes No
e) Have you ever felt annoyed that people were criticizing your drinking? Yes No

Do you use any substances or recreational drugs? Yes No
Do you use sunscreen or protective clothing? Yes No
Have you fallen in the past 12 months? Yes No
Are you afraid of falling? Yes No
Do you wear seatbelts consistently? Yes No
Do you wear a bicycle helmet when bicycling or rollerblading? Yes No
Do you feel safe in your current relationship? Yes No
Do you have any guns in your home? Yes No
Are you currently sexually active? Yes No
Do you have any questions about sexual relations? Yes No
Do you practice safe sex (monogamous relationship, condoms, celibate)? Yes No
Do you have any questions regarding safer sex? Yes No
Do you have any questions or problems regarding your mental health? Yes No
Over the past two weeks, have you felt depressed or hopeless? Yes No
Over the past two weeks, have you lost interest in things you usually enjoy? Yes No
Have you ever been treated for depression and/or anxiety? Yes No
Do you have any questions about your diet? Yes No
Do you try to avoid eating simple, white carbohydrates and highly processed foods? Yes No
Do you eat a low-saturated-fat, low-cholesterol diet? Yes No
What exercise do you perform regularly? _____
Duration: _____ How many times PER WEEK?_____

Do you practice any of the following to relax?
a) Meditate Yes No
b) Pray Yes No
c) Listen to music Yes No
d) Yoga Yes No
e) Tai Chi Yes No
f) Relaxation breathing Yes No

Name: _____

Did you see your dentist within the last year? Yes No

If yes, date:_____

Did you see your ophthalmologist (eye doctor) within the past year? Yes No

If yes, date:_____

How many hours do you sleep each night? _____

Are you rested in the morning? Yes Mostly Yes Mostly No No

Do you have a Health Care Proxy? Yes No

FAMILY HISTORY *(Please update with any changes since last visit)*

Relative	Living		Age	Medical Problems and/or Cause of Death
Mother	Yes	No	_____	_____
Father	Yes	No	_____	_____
Brother 1	Yes	No	_____	_____
Brother 2	Yes	No	_____	_____
Brother 3	Yes	No	_____	_____
Sister 1	Yes	No	_____	_____
Sister 2	Yes	No	_____	_____
Sister 3	Yes	No	_____	_____
Maternal Grandmother	Yes	No	_____	_____
Maternal Grandfather	Yes	No	_____	_____
Paternal Grandmother	Yes	No	_____	_____
Paternal Grandfather	Yes	No	_____	_____

Any family members (parents, siblings, grandparents, aunts/uncles) have the following:

Colon Cancer: _____ Prostate Cancer: _____

Breast Cancer: _____ Uterine Cancer: _____

Melanoma: _____ Ovarian Cancer: _____

Hypertension (high BP): _____ Diabetes: _____

Strokes: _____ Heart Attacks: _____

_____ _____

HEALTH MAINTENANCE

When was your last tetanus shot? _____

If you are a woman 40 years or older, when was your last mammogram? _____

If you are 45 years or older, when was your last colonoscopy? _____

If you are 50 years or older, have you had a shingles shot? Yes No

If you are 65 years or older, have you had a pneumonia shot? Yes No

If you are 65 years or older, have you had a bone density test? Yes No

ADDITIONAL QUESTIONS

To whom do you talk with for support in a time of need?

_____

If married or in a long-term relationship, how is the relationship for you?

_____

How is work for you?

_____

How is your family situation? _____

Needham Wellesley Family Medicine Nutrition Checklist

Name:_____Date: _____

How many portions PER DAY do you eat of the following?

Vegetables [1 portion = 1 cup (size of fist)]	0	1	2	3	4	5	6+
Fruit [1 portion = 1 cup (size of fist)]	0	1	2	3	4	5	6+
Quinoa, lentils, beans, peas, whole grains, chickpeas [1 portion = 1/2 cup (half a fist)]	0	1	2	3	4	5	6+
Lean protein (chicken, turkey, fish, tofu, egg whites) [1 portion = 4 oz (half a fist)]	0	1	2	3	4	5	6+
Olive oil [1 tbsp (size of thumb tip)]	0	1	2	3	4	5	6+
Glasses of water [1 cup (size of fist)]	0	1	2	3	4	5	6+
Glasses of milk [1 cup], Cheese [1 slice], Plain Yogurt [1 cup]	0	1	2	3	4	5	6+
Nuts [10 per portion] (raw or roasted)	0	1	2	3	4	5	6+
Caffeinated drinks (coffee, tea) [1 cup]	0	1	2	3	4	5	6+
Energy drinks, soda with caffeine [1 cup]	0	1	2	3	4	5	6+
White bread, white pasta, white potatoes, white rice, white flour	0	1	2	3	4	5	6+
Sugar or artificial sweetener	0	1	2	3	4	5	6+

How many times PER WEEK do you eat the following?

Salads	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Fish [1 portion = 4 oz (half a fist)]	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Snacks (ex: raw nuts, fresh fruits, or veggies)	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
White bread, white pasta, white potatoes, white rice, white flour	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Fast food meals	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Fried foods, pastries, chips	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Candy or dried fruit	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Energy bars or granola bars	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Sugar cereals, granola	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Desserts, sweets, ice cream	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Smoothies and shakes	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Soda (regular or diet) or Frappuccinos, etc.	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Fruit juice or fruit blends	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Sports drinks (Gatorade, etc)	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Meal replacement drinks (eg. Slim Fast), protein drinks or powders	0	1	2	3	4	5	6	7	8-14x	15-21x	22+
Alcohol servings [12 oz beer, 5 oz wine, 1.5 oz spirits]	0	1	2	3	4	5	6	7	8-14x	15-21x	22+

What time do you begin eating each morning? _____

White time do you finish eating dinner each evening? _____

Revised 08/10/22

Name:_____Preferred to be called_____
Last *First* *MI.*

Date of Birth:____/___/_____Age:_____Sex:____Male____Female Marital Status: ___Married___Single___Divorced___Widowed

_____SSN_____
Employer Name Employer Address Employer Phone No.

If referred by a Physician: _____
Name of Physician Physician's Address

ADDRESS:
Mailing Address_____
City *State* *Zip*
Home Phone ( )_____Cell Phone ( )_____e-mail:_____

Person to contact in case of emergency: _____
Name *Address* *Phone #*

To whom may we discuss your care? _____
Name *Address* *Phone #*

Has any other member of your family been treated in our office? Yes No
If yes:

PARENT, SPOUSE, OR RESPONSIBLE PARTY (If different from patient)

Name: _____ Date of Birth_____/____/_____
Last *First* *MI.*

Address_____
City *State* *Zip*

Home/Cell Phone ( )_____Work Phone ( )_____e-mail:_____

INSURANCE COVERAGE — PRIMARY:

Insurance Co. Name:_____Policy #_____

Insurance Address: _____
City *State* *Zip*
Name of Policy Holder (Insured)_____Policy Holder's DOB____/____/____

Group Name or Employer #_____Relationship, to insured:____Self____Spouse___Child

INSURANCE COVERAGE — SECONDARY: Pharmacy Used: _____

Insurance Co. Name:_____Policy #_____

Insurance Address: _____
City *State* *Zip*
Name of Policy Holder (Insured)_____Policy Holder's DOB____/____/____

Group Name or Employer #_____Relationship, to insured:____Self____Spouse___Child

In order to establish optimal relations with our patients and avoid misunderstanding regarding our patient policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE FOR "YOUR CO-PAYMENT OR YOUR PORTION OF THE CHARGES". FOR YOUR CONVENIENCE WE ACCEPT VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. If you do not have insurance, payment in full is expected at the time of service, unless payment arrangements have been made. Balances on all accounts not secured with valid credit card on file will be subject to statement fees and interest as defined on NWFM's Credit Card policy sheet. Any account turned over to collection agency for non-payment will be subjected to added collection costs and attorney fees. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes Needham Wellesley Family Medicine to release such medical information necessary to process your insurance claims, if any, and authorizes payment of medical benefits to the physician when assigned claim is filed

_____ Date____/_____/____
Signature of Patient or Legal Guardian