Gay Fulkerson, MD
Family Physician

Name: _____ Birth Date: _____ Today's Date: _____
Married Divorced Widowed Sex: _____
Allergies: _____

Have you had any of the following:

Pneumonia Vaccine No Yes
Hep B Vaccine x3 No Yes
Colorectal CA screen No Yes
Diabetes screening tests No Yes
Bone Mass Measure No Yes
Glaucoma Screen No Yes
Diabetes out pt. training No Yes
Cardiovascular blood test No Yes

Females

Date of last Menstrual period _____
Date of last Pap smear _____
Date of last Mammogram_____

Males

Date of last rectal exam _____
Date of last PSA (Prostate Test) _____

Family History

			Who				Who
Cancer	No	Yes	_____	Stroke	No	Yes	_____
Tuberculosis	No	Yes	_____	Epilepsy	No	Yes	_____
Diabetes	No	Yes	_____	Insanity	No	Yes	_____
Heart Trouble	No	Yes	_____	Suicide	No	Yes	_____

Illnesses: Have you ever had:

Rheumatic Fever	No	Yes	Ulcers	No	Yes	Resp. Disease	No	Yes
Diphtheria	No	Yes	Hepatitis	No	Yes	Cancer	No	Yes
Tuberculosis	No	Yes	Sickle Cell	No	Yes	Seizure Disorder	No	Yes
Alzheimer	No	Yes	Blood Disorder	No	Yes	Heart Disease	No	Yes
Arthritis	No	Yes	Kidney Disorder	No	Yes	HIV Exposure	No	Yes
STD's	No	Yes	Thyroid Disease	No	Yes	Chest Pain	No	Yes
Mental Illness	No	Yes	Vision Disorder	No	Yes	Stroke	No	Yes
Pacemaker	No	Yes	Diabetes	No	Yes	Hearing Problems	No	Yes
Hypertension	No	Yes	Depression	No	Yes	Other	No	Yes
Blood or Plasma Transfusion	No	Yes	Alcohol use	No	Yes	Drug use	No	Yes

Any type of Surgery? _____ If so, what type? _____

Been in hospital with illness No Yes If yes, what type? _____

Activities Daily Living/ Mobility Status
Check any problems that apply.

Turning ☐ Dressing ☐ Sitting Down ☐ Feeding ☐ Arm Movement ☐ Toileting ☐
Leg Movement ☐ Sitting Balance ☐ Standing Balance ☐ Bathing ☐ Walking ☐ Transfers ☐

Type of Diet: Regular ☐ Diabetic ☐ Calorie Restricted ☐

Physical Activities: _____

FALLS RISK	NO	YES		NO	YES
Unsteady on feet			Poor Eyesight (glasses, contacts)		
Confused, disoriented			65 yrs. old or older		
Previous Fall			Taking sedatives, narcotics		
Dizziness/Fainting			Physical disabilities		
Unsafe footwear			Neurological problems		
Poor Bladder Control			Taking water pills		

HOME SAFETY	NO	YES		NO	YES	Water Source	
Smoke Alarms			Hand Rails			Well	Spring
Type of Heating			Floor Rugs			City	County
Type of Cooling			Steps in home				