CONFIDENTIAL MEDICAL REPORT

New Ulm Medical Center
1324 Fifth Street North
New Ulm, MN 56073
T | 507-217-5168
F | 507-217-5255

Patient Label

Patient Health History Form

Today's Date:_____

THANK YOU for allowing me to collaborate with you on your health. I'm honored to serve you.

Please take a few minutes to answer the questions on the following pages. This information will help me understand how you've been doing lately. It will also give me a sense for what's been going on in your life.

—David A. Frenz, M.D.

What can I help you with today? (*Please write in this box*)

Version: 02/03/2019

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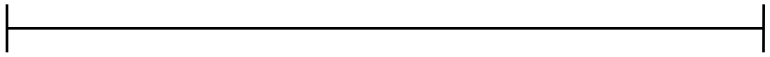
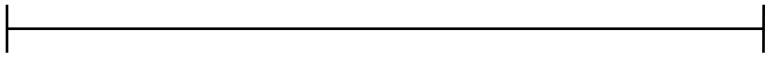
Really Big Picture

Looking back over the last week, including today, help me understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. (*Please ask Dr. Frenz to explain this page to you before you complete it for the first time*)

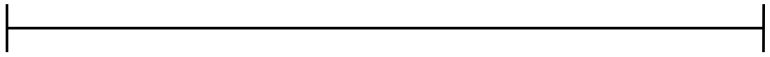
Individually
(Personal well-being)



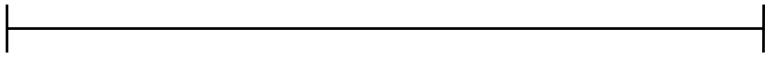
Interpersonally
(Family, close relationships)



Socially
(Work, school, friendships)



Overall
(General sense of well-being)



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Chemical Health

Which drugs or chemicals have you used in the past 30 days?
(*Please mark all the boxes that apply*)

- ☐ Alcohol
- ☐ Cocaine
- ☐ Heroin
- ☐ Marijuana (does not include medical cannabis)
- ☐ Methamphetamine
- ☐ Prescription medications (not prescribed to you)
- ☐ Tobacco (cigarettes, cigars, “chew”)

Looking back over the last week, including today, how often did you think about or have urges to drink alcohol or use drugs? (*Please mark one box*)

- ☐ Never
- ☐ Rarely
- ☐ Occasionally
- ☐ Sometimes
- ☐ Often
- ☐ Most of the time
- ☐ Nearly all of the time

How troubled or bothered have you been in the past 30 days by alcohol problems?
(*Please mark one box*)

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Considerably
- ☐ Extremely

How troubled or bothered have you been in the past 30 days by drug problems?
(*Please mark one box*)

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Considerably
- ☐ Extremely

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Patient Health History Form

Mental Health

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(*Please mark one box for each row*)

	A	B	C	D
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
—				
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐

A = Not at all **B** = Several days
C = More than half the days **D** = Nearly every day

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Patient Health History Form

Mental Health

Over the last 2 weeks, how often did you feel this way or have these things happen to you?
(*Please mark one box for each row*)

	A	B	C	D
Felt so hyper that you got into trouble	☐	☐	☐	☐
Felt so good or so hyper that other people thought you were not your normal self	☐	☐	☐	☐
Felt so irritable that you shouted at people or started fights or arguments	☐	☐	☐	☐
—				
Thought about killing someone or physically hurting them in some way	☐	☐	☐	☐
Believed that people were spying on you, or that someone was plotting against you, or trying to hurt you	☐	☐	☐	☐
Heard things other people couldn't hear, such as voices	☐	☐	☐	☐
Had visions when you were awake or saw things other people couldn't see	☐	☐	☐	☐

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Physical Health

Over the last 2 weeks, how much did you feel this way or have these things happen to you?
(*Please mark one box for each row*)

	E	F	G	H
Sedation, drowsiness or nodding off	☐	☐	☐	☐
Blurry vision	☐	☐	☐	☐
Dry mouth	☐	☐	☐	☐
Upset stomach or nausea	☐	☐	☐	☐
Hard stools (poop) or constipation	☐	☐	☐	☐
Loose stools (poop) or diarrhea	☐	☐	☐	☐
Trouble urinating (peeing) or emptying your bladder	☐	☐	☐	☐
Problems with sex	☐	☐	☐	☐
Shaking or tremor	☐	☐	☐	☐
Hot or cold flashes	☐	☐	☐	☐
Sweating too much	☐	☐	☐	☐

E = Not at all **F** = A little bit
G = Quite a bit **H** = Very much

Over the last 2 weeks, did any of the following things happen to you?
(*Please mark one box for each row*)

	Yes	No	Unsure
Fainting or passing out	☐	☐	☐
Falling down	☐	☐	☐
Seizure	☐	☐	☐

Your Signature:	Today's Date:

Form Owner: David A. Frenz, M.D.