

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Frequent or severe headaches..... Yes No
 Fainting spells..... Yes No
 Dizziness on change of position..... Yes No
 Unconscious Spells..... Yes No
 Any change in vision..... Yes No
 Do you wear glasses..... Yes No
 When were they last checked _____
 Earaches..... Yes No
 Discharge from Ears..... Yes No
 Ringing in ears..... Yes No
 Decrease in hearing..... Yes No
 Recurrent nose bleeds..... Yes No
 Recurrent head colds..... Yes No
 Sinus Trouble..... Yes No
 High fever..... Yes No
 Strange persistent odors..... Yes No
 Strange taste or loss in taste..... Yes No
 Persistent hoarseness..... Yes No
 Difficulty swallowing..... Yes No
 Enlarged glands..... Yes No
 Recurrent sore throats..... Yes No
 Recurrent sores in mouth..... Yes No
 Soreness or bleeding of gums on brushing..... Yes No
 Chest pain..... Yes No
 Angina pectoris..... Yes No
 Coughed up blood..... Yes No
 Pain in arm(s)..... Yes No
 Night sweats..... Yes No
 Chronic or frequent cough..... Yes No
 Chronic or frequent cough on laying down..... Yes No
 Wake up at night short of breath..... Yes No
 How many bed pillows do you use _____
 Shortness of breath on:
 Walking several blocks..... Yes No
 one flight of stairs..... Yes No
 On laying down..... Yes No
 Purple lips or fingers..... Yes No
 Palpitations or fluttering of heart..... Yes No
 High blood pressure..... Yes No
 Swelling of hands, feet or ankles..... Yes No
 At what time of day..... Yes No
 Leg cramps on walking or at night..... Yes No
 Enlarged veins in legs..... Yes No
 Recurrent stomach pain..... Yes No
 Belching or heartburn..... Yes No
 Relieved by food or medication..... Yes No
 Appetite - Good Fair Poor
 Nausea or vomiting..... Yes No
 Vomited blood..... Yes No
 Abdominal cramping..... Yes No
 Color of bowel movement..... Yes No
 Any blood in BM..... Yes No
 Rectal pain with bowel movement..... Yes No
 Difficulty when urinate..... Yes No
 Lose urine on coughing or sneezing..... Yes No
 Discharge from penis..... Yes No
 Recurrent back pains..... Yes No
 Backaches..... Yes No
 Joint pains..... Yes No

Swelling of any joints..... Yes No
 Redness or heat of any joint..... Yes No
 Tingling or weakness of hands or feet..... Yes No
 Muscle Spasms..... Yes No
 Loss or change in sensation of hands or feet..... Yes No
 Trembling of any extremity..... Yes No
 Growth in neck or throat..... Yes No
 Hot flashes..... Yes No
 Tiredness without apparent reason..... Yes No
 Brittleness of nails..... Yes No
 Dryness of skin..... Yes No
 Easy bruising..... Yes No
 Inability to stand heat..... Yes No
 Inability to stand cold..... Yes No
 Change in hair texture..... Yes No
 Change in skin texture..... Yes No
 Any skin rash..... Yes No
 X-RAYS: Have you ever had x-rays of..... Yes No
 Chest..... Yes No
 Stomach or colon..... Yes No
 Gall bladder..... Yes No
 Extremities..... Yes No
 Back..... Yes No
 Teeth..... Yes No
 Other..... Yes No
 EKG: Ever had an electrocardiogram?..... Yes No
 IMMUNIZATIONS: have you had..... Yes No
 Flu vaccine..... Yes No
 Pneumonia..... Yes No
 Tetanus shots (not antitoxin which lasts only 2 weeks)..... Yes No
 Have you ever been treated for drug habits..... Yes No
 Have you ever taken hormone tablets or injections..... Yes No
WOMEN ONLY - MENSTRUAL HISTORY
 Age at onset.....
 Regular? Yes No Varies
 Cycle _____ days (from start to finish)
 Flow: Heavy medium Light
 Number of pads used per period..... Yes No
 Any clots passed..... Yes No
 Pains or cramps..... Yes No
 Date of last period..... Yes No
 Date of last pelvic exam..... Yes No
 Date of last Pap Test..... Yes No
 Results: Neg. Pos.
 Any discharge from vagina..... Yes No
 If so, color..... Yes No
 amount..... Yes No
 Any itching of vagina area..... Yes No
 Do you take birth control pills..... Yes No
 how long have you taken them..... Yes No
 Pregnancies:
 How many children born alive..... Yes No
 How many still births..... Yes No
 How many premature births..... Yes No
 How many Cesarean Sections..... Yes No
 How many miscarriages..... Yes No
 Any complications with pregnancy..... Yes No
 Describe.....
 Other.....



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“STAYING HEALTHY” ASSESSMENT

Adults, 18 years of age and older

Patient's name		Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Today's date		
<p>You and your health care team can work together towards better health. Please answer these questions as best as you can. You may check (✓) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.</p>						
Sample Question and Answer: Do you play sports?				<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Skip
Do You:						
1.	Receive health care from anyone besides a medical doctor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
2.	See the dentist once a year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
3.	Drink milk or eat yogurt or cheese at least 3 times each day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
4.	Eat at least 5 servings of fruits or vegetables each day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
5.	Try to limit the amount of fried or fast foods that you eat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
6.	Exercise or do moderate physical activity such as walking or gardening 5 days a week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
7.	Think you need to lose or gain weight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
8.	Often feel sad, down, or hopeless?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
9.	Have friends or family members that smoke in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
10.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		

Do you:

- 11. Smoke cigarettes or cigars or use any other kinds of tobacco? Yes No Skip
- 12. Use any drugs or medicines to go to sleep, relax, calm down, feel better, or lose weight? Yes No Skip
- 13. Often have more than two drinks containing alcohol in one day? Yes No Skip
- 14. Think you or your partner could be pregnant? Yes No Skip
- 15. Think you or your partner could have a sexually transmitted disease? Yes No Skip

Have You:

- 16. Or your partner(s) had sex without using birth control in the last year? Yes No Skip
- 17. Or your partner(s) had sex with other people in the past year? Yes No Skip
- 18. Or your partner(s) had sex without a condom in the past year? Yes No Skip
- 19. Ever been forced or pressured to have sex? Yes No Skip
- 20. Ever been hit, slapped, kicked, or physically hurt by someone? Yes No Skip
- 21. **Do you have other questions or concerns about your health?** Yes No Skip

(Please identify) _____

- 22. Do you receive the Pneumonia vaccine? No Yes Date: _____
- 23. Do you receive the Flu vaccine? No Yes Date: _____
- 24. Do you receive the Tetanus vaccine? No Yes Date: _____
- 25. Do you receive the Whooping Cough? No Yes Date: _____

NAME: _____
D.O.B: _____



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FAMILY PRACTICE
1968 N. GAREY AVE.
POMONA, CA 91767

DATE: _____

PHYSICAL SYMPTOMS (PHQ-15)

During the past 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
a. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain in your arms, legs, or joints (knees, hips, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Menstrual cramps or other problems with your periods WOMEN ONLY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Feeling tired or having low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(For office coding: Total Score T _____ = _____ + _____)

X _____

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

NAME: _____
 D.O.B: _____



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DATE: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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

FOR OFFICE CODING 0 + + +
 =Total Score:

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 other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

X _____

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY



EMSA #111 B
(Effective 4/1/2011)

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

A CARDIOPULMONARY RESUSCITATION (CPR): *If person has no pulse and is not breathing. When NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

- Attempt Resuscitation/CPR (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)
- Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B MEDICAL INTERVENTIONS: *If person has pulse and/or is breathing.*

Check One

- Comfort Measures Only** Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Transfer to hospital only if comfort needs cannot be met in current location.**
- Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
- Transfer to hospital only if comfort needs cannot be met in current location.**
- Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. **Transfer to hospital if indicated. Includes intensive care.**

Additional Orders: _____

C ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

- No artificial means of nutrition, including feeding tubes. Additional Orders: _____
- Trial period of artificial nutrition, including feeding tubes. _____
- Long-term artificial nutrition, including feeding tubes. _____

D INFORMATION AND SIGNATURES:

Discussed with: Patient (Patient Has Capacity) Legally Recognized Decisionmaker

Advance Directive dated _____ available and reviewed → Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Advance Directive not available

No Advance Directive

Signature of Physician
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name: HEMANT D.PATEL, M.D.	Physician Phone Number: 909-620-3858	Physician License Number: A51751
Physician Signature: (required)		Date:

Signature of Patient or Legally Recognized Decisionmaker
By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:	Relationship: (write self if patient)	
Signature: (required)	Date:	
Address:	Daytime Phone Number:	Evening Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F
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Health Care Provider Assisting with Form Preparation

Name:	Title:	Phone Number:
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Additional Contact

Name:	Relationship to Patient:	Phone Number:
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Directions for Health Care Provider

Completing POLST

- Completing a POLST form is voluntary. California law requires that a POLST form be followed by health care providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders.
- POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or treatments may prohibit a person from residing in a residential care facility for the elderly.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort Measures."
- Treatment of dehydration prolongs life. If person desires IV fluids, indicate "Limited Interventions" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment.
- A patient with capacity can, at any time, revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the individual or, if unknown, the individual's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.

For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED