LIBERTYDOCTORS
ASSURING HEALTHCARE FREEDOM

First Name: _____ **Last Name:** _____

Date of Birth: _____ **Today's Date:** _____

Medicare Health Risk Screening

1. How would you rate your exercise level? **Low Moderate Heavy**

2. Are you following any special diets, like maybe: diabetic, vegetarian, vegan or gluten free? **Yes No**

If yes, what diet:_____

3. Are you able to prepare your own meals? **Yes No**

4. How many meals do you eat per day? **One Two Three**

5. Do you have trouble with finding transportation? **Yes No**

6. Would you say you have had any difficulty in your normal daily activities? Like eating, bathing or dressing? **Yes No**
7. Is there anything in your home that might cause you to fall like maybe throw rugs or poor lighting? **Yes No**

8. Do you have handrails on any stairs or grab bars in your bathroom? **Yes No**

9. In the past 4 weeks would you say that your health has been: **Excellent Very Good Good Fair Poor**

10. Do you have any issues in your normal daily activities because of your eyesight (watching TV, driving...)? **Yes No**
11. Have you lost 10 or more pounds in the last 6 months without trying? **Yes No**

12. Do you have any trouble managing your medications on a daily basis? **Yes No**

13. Do you use any tobacco containing products? **Yes No**

If yes: _____

14. Do you use any illicit drugs? **Yes No**

If yes:_____

Fall Risk

1. Have you fallen in the past year? **Yes** **No**
    a. If yes: How many times? _____
    b. Were you injured as a result of the fall? **Yes** **No**
2. Do you feel unsteady when you walk? **Yes** **No**
3. Are you worried about falling at all? **Yes** **No**
4. Do you use a cane/walker? **Yes** **No**
5. Do you have to hold on to any furniture while walking or use furniture to stand up? **Yes** **No**
6. Do you have trouble stepping onto a curb? **Yes** **No**
7. Do you notice any numbness in your feet, or do your steps feel heavy? **Yes** **No**
8. Do you take any medications that make you feel lightheaded or more tired than usual? **Yes** **No**

Hearing Screening

1.	Does a hearing problem cause you to feel embarrassed when meeting new people?	Yes	Sometimes	No
2.	Does a hearing problem cause you to feel frustrated when talking to members of your family?	Yes	Sometimes	No
3.	Do you have difficulty hearing when someone speaks in a whisper?	Yes	Sometimes	No
4.	Do you feel handicapped by a hearing problem?	Yes	Sometimes	No
5.	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	Yes	Sometimes	No
6.	Does a hearing problem cause you to attend religious services less often than you would like?	Yes	Sometimes	No
7.	Does a hearing problem cause you to have arguments with family members?	Yes	Sometimes	No
8.	Does a hearing problem cause you difficulty when listening to TV or radio?	Yes	Sometimes	No
9.	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	Yes	Sometimes	No
10.	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	Yes	Sometimes	No

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?				
1. Little interest or pleasure in doing things	Not at All	Several Days	More than Half the Days	Nearly Every Day
2. Feeling down, depressed, or hopeless	Not at All	Several Days	More than Half the Days	Nearly Every Day
3. Trouble falling or staying asleep, or sleeping too much	Not at All	Several Days	More than Half the Days	Nearly Every Day
4. Feeling tired or having little energy	Not at All	Several Days	More than Half the Days	Nearly Every Day
5. Poor appetite or overeating	Not at All	Several Days	More than Half the Days	Nearly Every Day
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down	Not at All	Several Days	More than Half the Days	Nearly Every Day
7. Trouble concentrating on things, such as reading a newspaper or watching TV	Not at All	Several Days	More than Half the Days	Nearly Every Day
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	Not at All	Several Days	More than Half the Days	Nearly Every Day
9. Thoughts that you would be better off dead or of hurting yourself in some way	Not at All	Several Days	More than Half the Days	Nearly Every Day
10. If patient checked off any problems, how difficult have these problems made it for them to do their work, take care of things at home, or getting along with other people?	Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult

The Alcohol Use Disorders Identification Test

1. How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2	3 or 4	5 or 6	7-9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
11. Have you ever been in treatment for an alcohol problem?	Yes	Never	Currently	In the Past	

Preventative Screening

1.	Have you had a Lipid Panel?	Yes	No	If yes, date: _____
2.	Have you had a Prostate Screening? (Males Only)	Yes	No	If yes, date: _____
3.	Have you had an A1C?	Yes	No	If yes, date: _____
4.	Have you had a Prevnar 13 immunization?	Yes	No	If yes, date: _____
5.	Have you had a Pneumovax immunization?	Yes	No	If yes, date: _____
6.	Have you had a Tetanus Shot?	Yes	No	If yes, date: _____
7.	Have you had a Shingles Vaccination?	Yes	No	If yes, date: _____
8.	Have you had an Influenza Vaccination?	Yes	No	If yes, date: _____
9.	Have you had a Glaucoma test?	Yes	No	If yes, date: _____
10.	If you are a Diabetic patient, have you had a Diabetic Eye Exam to screen for Retinopathy?	Yes	No	If yes, date: _____
11.	Have you had a Colorectal Cancer Screening?	Yes	No	If yes, date: _____
12.	Have you had a Pap Smear? (Females Only)	Yes	No	If yes, date: _____
13.	Have you had a Mammogram? (Females Only)	Yes	No	If yes, date: _____
14.	Have you had a Bone Density Test?	Yes	No	If yes, date: _____
15.	Have you had an Abdominal aortic aneurysm screening?	Yes	No	If yes, date: _____