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| **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:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you able to prepare your own meals? **Yes No**
2. How many meals do you eat per day? **One Two Three**
3. Do you have trouble with finding transportation? **Yes No**
4. Would you say you have had any difficulty in your normal daily activities? Like eating, bathing or dressing? **Yes No**
5. Is there anything in your home that might cause you to fall like maybe throw rugs or poor lighting? **Yes No**
6. Do you have handrails on any stairs or grab bars in your bathroom? **Yes No**
7. In the past 4 weeks would you say that your health has been: **Excellent Very Good Good Fair Poor**
8. Do you have any issues in your normal daily activities because of your eyesight (watching TV, driving...)?

**Yes No**

1. Have you lost 10 or more pounds in the last 6 months without trying? **Yes No**
2. Do you have any trouble managing your medications on a daily basis? **Yes No**
3. Do you use any tobacco containing products? **Yes No**

**If yes:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**If yes:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fall Risk**

1. Have you fallen in the past year? **Yes No**
   1. If yes: How many times? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
   2. 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 |
| 1. Does a hearing problem cause you to feel frustrated when talking to members of your family? | Yes | Sometimes | No |
| 1. Do you have difficulty hearing when someone speaks in a whisper? | Yes | Sometimes | No |
| 1. Do you feel handicapped by a hearing problem? | Yes | Sometimes | No |
| 1. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors? | Yes | Sometimes | No |
| 1. Does a hearing problem cause you to attend religious services less often than you would like? | Yes | Sometimes | No |
| 1. Does a hearing problem cause you to have arguments with family members? | Yes | Sometimes | No |
| 1. Does a hearing problem cause you difficulty when listening to TV or radio? | Yes | Sometimes | No |
| 1. Do you feel that any difficulty with your hearing limits or hampers your personal or social life? | Yes | Sometimes | No |
| 1. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? | Yes | Sometimes | No |

**Patient Health Questionnaire (PHQ-9)**

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| --- | --- | --- | --- | --- |
| **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 |
| 1. Feeling down, depressed, or hopeless | Not at All | Several Days | More than Half the Days | Nearly Every Day |
| 1. Trouble falling or staying asleep, or sleeping too much | Not at All | Several Days | More than Half the Days | Nearly Every Day |
| 1. Feeling tired or having little energy | Not at All | Several Days | More than Half the Days | Nearly Every Day |
| 1. Poor appetite or overeating | Not at All | Several Days | More than Half the Days | Nearly Every Day |
| 1. 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 |
| 1. 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 |
| 1. 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 |
| 1. 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 |
| 1. 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**

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| --- | --- | --- | --- | --- | --- |
| 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 |
| 1. 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 |
| 1. How often do you have six or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| 1. 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 |
| 1. 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 |
| 1. 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 |
| 1. 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 |
| 1. 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 |
| 1. Have you or someone else been injured because of your drinking? | No |  | Yes, but not in the last year |  | Yes, in the last year |
| 1. 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 |
| 1. Have you ever been in treatment for an alcohol problem? | Yes | Never | Currently | In the Past |  |

**Preventative Screening**

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| --- | --- | --- |
| 1. Have you had a Lipid Panel? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had a Prostate Screening? (Males Only) | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had an A1C? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had a Prevnar 13 immunization? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had a Pneumovax immunization? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had a Tetanus Shot? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had a Shingles Vaccination? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had an Influenza Vaccination? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had a Glaucoma test? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. If you are a Diabetic patient, have you had a Diabetic Eye Exam to screen for Retinopathy? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had a Colorectal Cancer Screening? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had a Pap Smear? (Females Only) | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had a Mammogram? (Females Only) | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had a Bone Density Test? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Have you had an Abdominal aortic aneurysm screening? | Yes No | If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |