Patient Name:	Date of Birth:
Date of Exam:	Physician:

List of your Providers and Suppliers – (RFV)

PCP: _____
Cardiology: _____
Gastroenterology: _____
Ophthalmology: _____
Pharmacy: _____
Durable Medical Equipment: _____
Any other Provider: _____

History - Health Maintenance

When was your last colorectal cancer screening? _____
Kind of test done: Colonoscopy _____ Sigmoidoscopy _____ Fecal test _____

When was your last bone density study (Dexa scan)? _____
When was your last Annual Physical Examination? _____
When was your last eye examination? _____
When was your last dental checkup? _____

Women only:
When was your last mammogram? _____
When was your last Pap smear? _____
LMP: _____
Pertinent History: Postmenopausal ___ Menopause ____ Hysterectomy ____

Men Only:
When was your last digital rectal exam? _____
When was your last PSA blood test? _____

History – Social – Safety

Do you use seat belts? Always: ____ Sometimes: ____ Never: ____
Do you use sunscreen? Always: ____ Sometimes: ____ Never: ____

History - Social – Drugs/Alcohol/Tobacco/Caffeine

Do you drink Alcohol? _____ If yes, how often? _____ How many per day? _____
Caffeine intake (How many per day): Coffee _____ Tea _____ Energy Drinks _____ Sodas _____
Do you use illicit drugs? _____ If yes, what drugs? _____ How Often? _____
Do you smoke? _____ If yes, for how long? _____ If you quit, when? _____
# of Cigarettes per day? _____ Pipe? _____ Cigar? _____

Immunizations – Historical

Date of last flu shot?_____ Where? _____
Date of last Zoster vaccine (for Shingles)? _____ Where? _____
Date of last Hep B vaccine? _____ Where? _____
Date of last Pneumonia vaccine? _____ Where? _____

Patient Name:	Date of Birth:
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Functional Assessment (Results)

Cognition	Ambulation	Hearing	Speech	Vision
□ Excellent □ Diminished □ Dementia □ Alzheimer's □ Parkinson □ Alert □ Oriented □ Other: _____	□ Excellent □ Good □ Fair □ Another Person □ Scooter □ Wheelchair □ Walker □ Cane □ Amputation- R/L □ Prosthetics	□ Excellent □ Good □ Poor □ Hearing aid/device □ Deaf	□ Excellent □ Good □ Poor □ Post-Stroke □ Stutter □ Mute □ Slurred □ Normal	□ Excellent □ Good □ Poor □ Glasses/contacts □ Blind □ Cataracts □ Glaucoma □ Macular Degeneration □ DM Retinopathy

Activities of Daily Living (Results)

Do you need help with grooming?	□ Yes □ No
Do you need help with dressing?	□ Yes □ No
Do you need help with toilet use?	□ Yes □ No
Continent (bowel and/or bladder)?	□ Yes □ No
Is bladder control a problem for you?	□ Yes □ No
Do you need help with housework?	□ Yes □ No
Do you need help with shopping?	□ Yes □ No
Do you need help with preparing meals?	□ Yes □ No
Do you need help with feeding?	□ Yes □ No
Do you need help with walking?	□ Yes □ No
Do you need help bathing?	□ Yes □ No
Do you need help transferring (in and out of chairs)?	□ Yes □ No
Does your physical health interfere with your daily activities?	□ Yes □ No

Advanced Care Planning (Results)

Patient has advanced directives:	□ Yes □ No
Patient has living will:	□ Yes □ No
Patient has surrogate decision maker/letter:	□ Yes □ No
Have you provided a copy to our office:	□ Yes □ No

Pain Screening - level of pain patient is in on a daily basis. (Vitals & Results)

0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10 Location of pain: _____

No pain Moderate Extreme Chronic Pain □ Yes □ No

Patient Name:	Date of Birth:
Date of Exam:	Physician:

Mental Health Screening- PHQ9 – (Results)

Over the last two weeks, how often have you been bothered by any of the following problems:

	Not at all	Several Days	More than 1/2 days	Everyday
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself?	0	1	2	3
Trouble concentrating on things?	0	1	2	3
Moving or speaking so slowly so other people could have noticed?	0	1	2	3
Thoughts that you would be better off dead or hurting yourself?	0	1	2	3

Assistant to fill in total) 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 Somewhat difficult Very difficult Extremely difficult

Fall Risk Screening – (Results)

Are you 65 Years or older?	□ Yes □ No
Have you fallen within the last 3 months?	□ Yes □ No
Are you unsteady on your feet or have a general weakness?	□ Yes □ No
Are you taking any medications that cause fatigue or dizziness?	□ Yes □ No
Have you had a stroke in the past?	□ Yes □ No
Do you have a progressive neurological disease?	□ Yes □ No
Do you have diabetes?	□ Yes □ No
Do you have neuropathy, arthritis or joint disease of the lower extremities?	□ Yes □ No
Do you have visual disturbances?	□ Yes □ No
Do you have fatigue, dizziness or declined agility?	□ Yes □ No
Do you have a fear of falling?	□ Yes □ No
Do you have painful feet?	□ Yes □ No
Do you have to rush to get to the bathroom in time?	□ Yes □ No

To be completed by physician:

□ Low risk for falls

□ High risk for falls