Health History Updates

Patient Preferences

Do you have a new preferred pharmacy? __ YES __ NO
Do you have a new preferred laboratory? __ YES __ NO
List any health care providers you have seen at least once in the past year.

Home Vital Signs

Enter your current pain level ________ where 0 equals no pain up to 10 equals worst pain.
If you check home blood pressure, enter the average reading you get _____/_____.

Medication History Update

Have you stopped any medications since your last office visit here? ___ YES ___NO
List any over the counter medications/supplements/herbs you take at least once a week.

Social History Update

Do you have a living will? ___ YES ___ NO
Do we have a copy of your living will? ___YES ___NO
Do you have a medical power of attorney? ___YES ___NO
Do we have a copy of your medical power of attorney? ___YES ___NO
Do you currently smoke cigarettes? ___YES ___NO
If yes, how many packs of cigarettes per day do you smoke? ___YES ___NO

Please check all that apply to you.

<u>Diet</u>
___Healthy Diet
___High in starch/sugar (bread, pasta, crackers, baked goods, sugary drinks, etc.)
___Less than 1 serving of fruit a day
___Less than 1 serving of vegetables a day
___High in salt
___High in fat
___Low in calcium (dairy or calcium fortified food)

<u>Dental Health</u>
___Not seen a dentist in greater than 12 months
___Wear dentures
___None apply to me

<u>Physical Activity</u>
___Exercise less than 150 minutes (2.5hrs) per week at moderate intensity (causes mild breathlessness)
___Sitting Lifestyle (sitting greater than 5 hours per day)
___Use cane, walker, or wheelchair with activity
___None apply to me

<u>Memory and Concentration</u>
___Trouble remembering recent events or conversations
___Troubling finding simple words or expressing thoughts
___Trouble remembering directions to familiar places
___Trouble solving problems
___None apply to me

<u>Speech/Motor Difficulties</u>
___Problems with speaking
___Trouble writing/copying
___Trouble picking up very small objects
___None apply to me

<u>Hearing</u>
___Difficulty hearing over background noise (e.g. restaurants)
___Off and on hearing loss
___Loss of hearing in one ear only
___Wears hearing aids
___Require high volume on TV
___Loss of hearing in both ears
___Has or had hearing aids, but does not wear them
___None apply to me

<u>Vision</u>
___Blurred or abnormal vision
___Trouble seeing in bright light or glare
___Trouble seeing at night
___Blind spots in vision
___Seeing double images with fatigue
___None apply to me

<u>Activities of Daily Living</u>
___Unable to bathe without assistance
___Leakage of urine has occurred in past 3 months
___Unable to get out of chair or bed without assistance
___Unable to use toilet without assistance
___Unable to dress without assistance
___Unable to feed self without assistance
___Unable to groom without assistance
___None apply to me

Instrumental Activities of Daily Living
___Unable to do house work without assistance
___Unable to manage medications without assistance
___Unable to manage money without assistance
___Unable to grocery shop without assistance
___Unable to drive without assistance
___Unable to use the phone without assistance
___Unable to prepare meals without assistance
___Unable to use public transportation without assistance
___None apply to me

Home Safety
___Throw rugs not well secured on floor
___No smoke/CO detectors
___Do not have hand bars in the bathroom/shower
___2 or more sexual partners in the last month
___No handrail on stairs
___Poor lighting in the home
___Sunscreen not routinely used
___None apply to me

Vehicle Safety
___Have been in a traffic accident in the past 1 year
___Do not wear a helmet if riding a motorcycle
___Do not wear seat belts in car all the time
___Do not wear helmet riding a bicycle
___None apply to me

Pain Severity
___Pain affects ability to do normal daily activities (dressing, bathing, and light household chores)
___Pain affects ability to do activities outside the home (shopping and social gathering)
___Pain affects ability to get sleep
___None apply to me

Pain Locations
___Frequent joint or muscle pain
___Frequent headaches that make it difficult to function during the day
___Frequent Abdominal Pain
___None apply to me

Alcohol Misuse Screening
___During a typical week drink more than 7 servings of alcohol if a female and more than 14 servings if a male (1 serving = 12 oz beer or 8 oz malt liquor or 5 oz wine or 1.5 oz shot of hard liquor)
___Have drank 4 or more servings of alcohol if a female or 5 or more servings if a male over a 2-3 hour period on one or more occasions in the past year
___None apply to me

Depression Screening – Patient Health Questionnaire

PHQ-2	Over the ***last 2 weeks***, how often have you been bothered by any of the following problems?	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

Fall Risk Assessment

___Have fallen 1 time in the past 12 months
___Injury with a fall in the past 12 months
___You feel unsteady
___Have fallen 2 or more times in the past 12 months
___Have a fear of falling
___**None apply to me**

Patient Signature: ____ Date: ____________________