Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications List (1159F and 1160F)**

|  |  |  |
| --- | --- | --- |
| **Name of Medicine** | **Dose** | **How medication is taken (1 daily, PRN)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ADVANCED DIRECTIVES (1157F or 1158F)**

Do you have a living will or advanced directive? □ Yes □ No

Do you have a DNR (Do Not Resuscitate)? □ Yes □ No

Do you have a durable power of attorney for healthcare? □ Yes □ No

If no to the above questions, are you open to discussion

with your provider? □ Yes □ No

**PREVENTATIVE CARE**

When was the last time you had:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Preventative Care** | In the last year | In the last 2-4 years | In the last 5 years | In the last 10 years | Never | Not applicable |
| Pneumonia Vaccine (4040F) |  |  |  |  |  |  |
| Shingles Vaccine |  |  |  |  |  |  |
| Breast Cancer Screening |  |  |  |  |  |  |
| Colorectal Cancer Screening |  |  |  |  |  |  |
| Cervical Cancer Screening |  |  |  |  |  |  |

Have you had a flu shot (G8482) this year? □ Yes □ No

**ACTIVITIES OF DAILY LIVING/FUNCTIONAL**

1. Do you have difficulties walking?

No □

Sometimes □

Yes, often □

Not applicable, I cannot walk □

1. Can you get to places not in walking distance without help?

\*For example, can you travel alone by bus, taxi, or drive your own car?

Yes **□**

No **□**

1. Can you shop for groceries or clothes without help?

Yes **□**

No **□**

1. Can you prepare your own meals?

Yes **□**

No **□**

1. Can you do your own housework without help?

Yes **□**

No **□**

1. Can you handle your own money without help?

Yes **□**

No **□**

1. Do you need help eating, bathing, dressing, or getting around your home?

Yes **□**

No **□**

**COGNITIVE SKILLS (1170F)**

1. Are you having difficulties driving your car?

No  □

Sometimes □

Yes, often □

Not applicable, I do not use a car **□**

1. Have you been given any information to help you keep track of your medications?

Yes **□**

No **□**

1. How often do you have trouble taking medicines the way you have been told to take them?

I do not have to take medicine **□**

I always take them as prescribed **□**

Sometimes I take them as prescribed **□**

I seldom take them as prescribed **□**

1. How often in the past 4 weeks, have you had problems using the telephone?

Never □

Seldom □

Sometimes □

Often □

Always □

1. During the past 4 weeks, was someone available to help you if you needed and wanted help? \*For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.

Yes, as much as I wanted **□**

Yes, quite a bit **□**

Yes, some **□**

Yes, a little **□**

No, not at all **□**

**NUTRITION**

1. How often in the past 4 weeks, have you had trouble eating well?

Never **□**

Seldom **□**

Sometimes **□**

Often **□**

Always **□**

**SAFETY**

1. Have you been given any information to help you identify hazards in your house that might hurt you?

Yes **□**

No **□**

1. Do you always fasten your seatbelt when you are in a car?

Yes, Usually **□**

Yes, Sometimes **□**

No **□**

**PAIN ASSESSMENT**

1. During the past 4 weeks, how much bodily pain have you generally had?

No pain (1126F) **□**

Very mild pain (1125F) **□**

Mild pain (1125F) **□**

Moderate pain (1125F) **□**

Severe pain (1125F) **□**

1. On a scale of 0-10, with 0 being no pain and 10 being the worst pain experience, what is your pain scale?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WELLNESS**

1. During the past 4 weeks, how would you rate your general health?

Excellent **□**

Very good **□**

Good **□**

Fair **□**

Poor **□**

1. Are you a smoker? (1034F)

No (1036F) **□**

Yes, and I might quit **□**

Yes, but I am not ready to quit **□**

1. Did you have a drink containing alcohol in the past year?

 Yes **□**

 No **□**

1. How have things been going for you in the past 4 weeks?

Very well – could hardly be better **□**

Pretty good **□**

Good and bad are about equal **□**

Pretty bad **□**

Very bad – could hardly be worse **□**

1. How confident are you that you can control and manage most of your health problems?

Very confident **□**

Somewhat confident **□**

Not very confident **□**

I do not have any health problems **□**

**DEPRESSION SCREENING (G044)**

1. Over the past 2 weeks, have you experienced having little interest or pleasure in doing things?

Yes **□**

No **□**

1. Over the past 2 weeks, have you been feeling down, depressed or hopeless?

Yes **□**

No **□**

**FALLS ASSESSMENT**

1. Have you fallen two (2) or more times in the past year?

Yes **□** (1101F)

No **□** (1100F)

1. Were you injured in any falls in the past year?

Yes **□**

No **□**

**BLADDER CONTROL (1090F)**

1. Do you experience urinary incontinence?

Yes **□**

No **□**

**PHYSICAL ACTIVITY (1103F)**

1. Do you exercise regularly?

Yes, daily **□**

Yes, > 3x week **□**

Yes, < 3x week **□**

No **□**

1. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?

 Very heavy **□**

Heavy **□**

Moderate **□**

Light **□**

Very light **□**

**SOCIAL DETERMINANTS OF HEALTH**

1. Do you find that sometimes you must choose between buying groceries or medications?

Yes **□**

No **□**

1. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY

 **□** Pests such as bugs, ants, or mice

 **□** Mold

 **□** Lead paint or pipes

**□** Lack of heat

**□** Oven or stove not working

**□** Smoke detectors missing or not working

**□** Water leaks

**□** None of the above

1. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

Yes **□**

No **□**

Already shut off **□**