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Name: _____ *Date:* _____

What doctor do you see for the following?

Colonoscopy/ GI Doctor:_____Last Exam:_____

Eye Doctor:_____ Last Exam:_____

GYN (females) Doctor:_____ Last Exam:_____

Heart Doctor:_____ Last Exam:_____

Lungs Doctor:_____ Last Appt:_____

Neurology Doctor:_____ Last Appt:_____

Urology Doctor:_____ Last Appt:_____

Any other doctors that you see:_____

Have you had any of the following tests done? If yes, when & where

DEXA/Bone Scan- Yes No When:_____ Where:_____

Mammogram Yes No When:_____ Where:_____

Stress Test Yes No When:_____ Where:_____

Have you had any of the vaccines? If yes, when & where

Pneumonia Yes No When:_____

Tetanus Yes No When:_____

Zostavex / Shingles Yes No When:_____

Flu Shot Yes No When:_____

Generic Health Questionnaire

Patients Name:_____ Date:_____

Instructions: Please circle answers.

1. **General Health: In general, would you say your health is**

   Excellent Very Good Good Fair Poor

   How much bodily pain you had during the past 4 weeks?

   None Very Mild Mild Moderate Severe Very Severe

2. **Activities of Daily Living: Are you Independent (I) (can do by myself), require assistance (A) (need help from another person), or dependent (D) (cannot do at all) with each of the following tasks?**

Walking	**I**	**A**	**D**	**Using Telephone**	**I**	**A**	**D**
Dressing	**I**	**A**	**D**	**Shopping**	**I**	**A**	**D**
Bathing	**I**	**A**	**D**	**Preparing Meals**	**I**	**A**	**D**
Eating	**I**	**A**	**D**	**Housework**	**I**	**A**	**D**
Toileting	**I**	**A**	**D**	**Taking Medicines**	**I**	**A**	**D**
Driving	**I**	**A**	**D**	**Managing Finances**	**I**	**A**	**D**

3. **Geriatric Review of the Systems:**

   a. **Do you have difficulty driving, watching TV, or reading because of poor eyesight? ..... Yes No**

   b. **Can you hear normal conversation voice? ..... Yes No**

      Do you use hearing aids? ..... Yes No

   c. **Do you have problems with memory? ..... Yes No**

   d. **Do often feel sad or depressed? ..... Yes No**

   e. **Have you unintentionally lost weight in 6 months? ..... Yes No**

   f. **Do you have trouble with control of bladder? ..... Yes No**

      Do you have trouble with control of bowels? ..... Yes No

   g. **How many falls have you had in the last year? _____**

   h. **Do you drink alcohol? ..... Yes No**

      If yes, how many drinks per week? _____

4. **Do you live with anyone? ..... Yes No**

   If yes, Who? Spouse Child Other Relative Friend

   Who would help you in an emergency? _____

   Who would help you with health care decisions if you were not able to communicate your wishes? _____

5. **How many medications do you take, including prescribed, over the counter, and vitamins? _____**

   What is your system for taking your medicines?

   Pill Box List/chart Family help None

6. **Are you sexually active? ..... Yes No**
7. **Has anyone intentionally tried to harm you? ..... Yes No**
8. **Have you had a shot to prevent pneumonia? ..... Yes No**
9. **Please draw the face of the clock with all the numbers and the hands set to indicate 10 minutes after 11 o'clock.**

Memory: 3 items recall after 1 minutes (banana, sunrise, chair) #recalled _____

Patient Signature: _____ Date: _____

Reviewing Physician: _____ Date: _____

Patient Health Questionnaire

Name: _____ Date: _____

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

(Circle your answers)

	Not at all	1-2 days per week	3-5 days per week	6-7 days per week
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep or staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading newspaper or watching TV	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead, or hurting yourself in some way	0	1	2	3
Add Columns:		+		+
Total:				

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 people?	**Not Difficult at all _____** **Somewhat difficult _____** **Very difficult _____** **Extremely difficult _____**