Health History Updates

Patient Preferences

Do you have a new preferred pharmacy? ☐ **Yes** ☐ **No**

Do you have a new preferred laboratory? ☐ **Yes** ☐ **No**

List below all health care providers you have seen at least once in the past 1-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.

Family History Update

List below any new diseases in your parents or brother(s)/sister(s).

Surgical /Medical History Update

List below any major surgeries or hospitalizations you have had within the past 1-year.

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? _____

_____
patient initials

Patient Label

Medicare Health Risk Assessment

Place a check mark by all that apply to you

Diet

☐ Healthy diet ☐ High in starch/sugar (bread, pasta, crackers, baked goods, sugary drinks, etc.)
☐ Less than 1 serving of fruit daily ☐ Less than 1 serving of vegetables daily
☐ High in salt ☐ High in fat ☐ Low in calcium (dairy or calcium fortified foods)

Dental Health

☐ Not seen a dentist in greater than 12 months ☐ Wear dentures ☐ **None apply to me**

Physical Activity

☐ Exercise less than 150 minutes (2.5hr)/week at moderate intensity (causes mild breathlessness)
☐ Use cane, walker or wheelchair with activity
☐ Sitting lifestyle (sitting greater than 5 hours per day)
☐ **None apply to me**

Memory and Concentration

☐ Trouble remembering recent events or conversations ☐ Trouble solving problems
☐ Trouble finding simple words or expressing thoughts
☐ Trouble remembering directions to familiar places ☐ **None apply to me**

Speech/Motor difficulties

☐ Problems with speaking ☐ Trouble picking up very small objects
☐ Trouble writing/copying ☐ **None apply to me**

Hearing

☐ Difficulty hearing over background noise (e.g. restaurant) ☐ Loss of hearing in both ears
☐ Off and on hearing loss ☐ Loss of hearing in one ear only ☐ Has or had hearing aids but does not wear them
☐ Wears hearing aids
☐ Require high volume on TV ☐ **None apply to me**

Vision

☐ Blurred or abnormal vision ☐ Blind spots in vision
☐ Trouble seeing in bright light or glare ☐ Seeing double images with fatigue
☐ Trouble seeing at night ☐ **None apply to me**

Activities of Daily Living

☐ Unable to bathe without assistance ☐ Unable to dress without assistance
☐ Leakage of urine has occurred in past 3 months ☐ Unable to feed self without assistance
☐ Unable to get out of chair or bed without assistance ☐ Unable to groom without assistance
☐ Unable to use toilet without assistance ☐ **None apply to me**

_____
patient initials

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 partner in the last 6 months
- ☐ 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 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 gatherings)
- ☐ 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 or more than 14 servings if a male (1 serving= 12oz beer or 8oz malt liquor or 5oz wine or 1.5oz-1shot 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 1 or more occasions in the past 12 months
- ☐ **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/Time

Patient Label