HEALTH ASSESSMENT SCREENING FORM

GO402	Welcome to
G0438	First Annual
G0439	Subsequent
_____	Other Code

PATIENTS NAME: _____ **DATE OF BIRTH:** _____ **DATE OF SERVICE:** _____

PLEASE LIST CURRENT MEDICATION, ALSO OVER THE COUNTER MEDICATIONS List below or Attach along with these forms
Current Patients-Please see attached list from your medication history (Make any changes to that list)
New Patients-Please list or attach all Medications and dosage you are currently taking

Medication Name and Strength / How many times daily? / Who prescribed it?

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

***DIETARY HISTORY*-Please place a check mark next to which ever best describes your daily dietary habits**

- o **Normal Balanced Diet for your Age**
- o **High in Carbohydrates**
- o **High in Fats**
- o **High in Protein**
- o **Other Diet**_____

***PHYSICAL ACTIVITY*- Please place a check mark next to which ever best describes you**

- o **ATHLETIC- Would you say you are Athletic (doing any of the following: jogging, swimming, running)**
- o **NORMAL ACTIVE-for your age (walking, cooking, housekeeping)**
- o **SEDENTARY-Without physical exercise**
- o **LIMITED ACTIVITY-Slow Walking, Needing a walker, cane or other devise to assist you**
- o **SIGNIFICANTLY LIMITED ACTIVITY**
- o **NONE / IMMOBILE**

***COGNITIVE IMPAIRMENT*-Please CIRCLE either yes or no to the following questions**

YES NO Difficulty Learning Retaining New Information (Example: Remembering names after the first introduction)

YES NO Difficulty Handling Complex Tasks

YES NO Difficulty with Reasoning

YES NO Difficulty with Spatial Ability /Orientation (Example: Sense of direction, following directions, visualization, navigating)

YES NO Difficulty with Language (Example: Having trouble coming up with words, slow speech)

YES NO Difficulty with Behavior (Example: Confusion, aggression, anxiety, or behavior changes)

YES NO OTHER_____

Patient Health **(Form 1)**

Patient Name_____ Date of Birth_____

	DEPRESSION ASSESSMENT ***Within the last 14 days, how often have you been bothered by any of the following problems?**	***0 POINTS*** **0 DAYS**	***1 POINT*** **1 to 6 Days**	***2 POINTS*** **7 to 11 Days**	***3 POINTS*** **12 to 14 Days**
1	Little interest or pleasure in doing things				
2	Feeling down, depressed or hopeless				
3	Trouble falling asleep, staying asleep, or sleeping too much				
4	Feeling tired or having little energy				
5	Poor appetite or overeating				
6	Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
7	Trouble concentrating on such things as reading the newspaper or watching TV				
8	Moving or speaking so slowly that other people have noticed; or the opposite, being so fidgety or restless that you are moving around a lot more than usual				
9	Thinking that you would be better off dead or that you want to hurt yourself in some way				
	Total Points/Column:				

o **TOTAL DEPRESSION RISK SCORE_____**

	BLADDER SYMPTOM INVENTORY **How BOTHERED have you been by**	***0 POINTS*** ***NONE***	***1 POINT*** **Little Bit**	***2 POINTS*** **Somewhat**	***3 POINTS*** **Quite a Bit**	***4 POINTS*** **Greatly**	***5 POINTS*** **Very Intrusive**
1	Frequent Daytime Urination						
2	Nighttime Urination						
3	Daytime Urgency w/out Incontinence						
4	Nighttime Urgency w/out Incontinence						
5	Urine Incontinence but w/o Urgency						
6	Urine Incontinence WITH Urgency						
	Total Point / Column:						

o **TOTAL RISK SCORE_____**

PAIN SCREENING**-Please answer Yes or No**

- o **Do you suffer significantly from pain? YES _____ NO_____**
- o **From a Scale of 1-10, What is your average daily pain_____**
- o **Is your PCP or Pain Management Physician managing your pain? _____**

Functional Ability and Safety Assessment

REVIEW OF FUNCTIONAL ABILITY AND SAFETY

MOBILITY-Please check any medical equipment you use

- o Mobile Does No Need Assistance
- o Mobility Limited-Needs Assistance (with any of the below)
- o Cane
- o Walker
- o Seated Walker
- o Manual Wheel Chair
- o Electric Wheel Chair
- o Scooter Device
- o Immobile

Transfer

- o Transfer Does Not Need Assistance
- o Transfer Ability Limited-Needs Assistance
- o Mildly Impaired
- o Moderately Impaired
- o Severe Impaired

Toileting / Bathing

- o No Limitations
- o Mild Limitations
- o Moderate Limitations
- o Severe Limitations

FEEDING

- o No Limitations in Feeding
- o Mild Limitations in Feeding
- o Moderate Limitation in Feeding
- o Severed Limitation in Feeding

HEARING IMPAIRMENT

- o No Limitations in Hearing
- o Mild Limitations in Hearing
- o Moderate Limitations in Hearing
- o Severe Limitations in Hearing

_____ Yes Using a Hearing Aid

_____ No Not Using a Hearing

VISION IMPAIRMENT

- o No Limitations
- o Impaired
- o Right
- o Left
- o Both

DME EQUIPMENT-Do you have an of the following (Please Check)

- o Oxygen / Portable Oxygen
- o Nebulizer
- o Catheters

Other_____

Do you have any concerns with the following **(Please Circle)**

Yes	No	Vision
Yes	No	Balance
Yes	No	Ability to Get Around or Physical Activity
Yes	No	Memory Issues
Yes	No	Quitting Smoking
Yes	No	Weight Loss

END OF LIFE PLANNING- Do you have the following completed (Please check YES or NO)

Living Will Completed YES_____ NO_____ Advance Directives Completed YES_____ NO_____

Medical Durable POA Completed YES_____ NO_____

Current Medical Providers (Specialist) the patient is seeing	Type of Specialist	Reason (s) / Indications (examples: outpatient therapy, dialysis, medical conditions not handled by your PCP	Date of Last Appointment	Next Appointment Scheduled

FEMALE SCREENING	MALE SCREENING
Total Colonoscopy (Date) _____ ( ) Yes ( ) NO **Results_____**	**Total Colonoscopy (Date) _____ ( ) Yes ( ) NO** **Results_____**
Mammogram (Date)_____ ( ) Yes ( ) No **Mastectomy (Date)_____ Diagnosis _____** **Rt._____ Lt. _____ B/L_____** **Last Pap / Pelvic Exam_____**	**Prostate Exam (Date)_____ ( ) Yes ( ) No** **When was your last PSA (Date)_____** **Are you seeing a Urologist ( ) Yes ( ) No**
Dexa Scan (Date)_____ ( ) Yes ( ) No **Do you have Osteoporosis or Osteopenia ( ) Yes ( ) No**	**Dexa Scan (Date)_____ ( ) Yes ( ) No** **Do you have Osteoporosis or Osteopenia ( ) Yes ( ) No**
Date of your last Vision Exam_____ **Do you have Glaucoma ( ) Yes ( ) No** **Do you have Macular Degeneration ( ) Yes ( ) No** **Do you have Diabetic Retinopathy ( ) Yes ( ) No**	**Date of your last Vision Exam_____** **Do you have Glaucoma ( ) Yes ( ) No** **Do you have Macular Degeneration ( ) Yes ( ) No** **Do you have Diabetic Retinopathy ( ) Yes ( ) No**
In the past 6 months did you have any lab work order by a specialist **Labs (Date)_____ ( ) Yes ( ) No**	**In the past 6 months did you have any lab work order by a specialist** **Labs (Date)_____ ( ) Yes ( ) No**

Patients Signature: _____ Date: _____

Providers Signature Credentials Print Providers Name

_____ ( ) MD ( ) DO ( ) NP ( ) PA _____ Date of Service: _____