



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?

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

- ATHLETIC- Would you say you are Athletic (doing any of the following: jogging, swimming, running)
- NORMAL ACTIVE-for your age (walking, cooking, housekeeping)
- SEDENTARY-Without physical exercise
- LIMITED ACTIVITY-Slow Walking, Needing a walker, cane or other devise to assist you

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)

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

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

Patient Health (Form 1)

Patient Name _____ Date of Birth _____

<u>DEPRESSION ASSESSMENT</u>		<u>0 POINTS</u>	<u>1 POINT</u>	<u>2 POINTS</u>	<u>3 POINTS</u>
*Within the last 14 days, how often have you been bothered by any of the following problems?		0 DAYS	1 to 6 Days	7 to 11 Days	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:					

TOTAL DEPRESSION RISK SCORE _____

0 Low Risk
4-7 Mild Risk

1-3 Minimal Risk
13-16 Moderate to Severe Risk

8-12 Moderate Risk
17+ Severe Risk

<u>BLADDER SYMPTOM INVENTORY</u>		<u>0 POINTS</u>	<u>1 POINT</u>	<u>2 POINTS</u>	<u>3 POINTS</u>	<u>4 POINTS</u>	<u>5 POINTS</u>
How BOTHERED have you been by		<u>NONE</u>	<u>Little Bit</u>	<u>Somewhat</u>	<u>Quite a Bit</u>	<u>Greatly</u>	<u>Very Intrusive</u>
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:							

TOTAL RISK SCORE _____

0- Asymptomatic

3-5 Mild Symptoms

11-15 Severe Urinary Symptoms

1-2 Minimal Symptoms

6-10 Moderate Symptoms

16+ VERY Severe Urinary Symptoms

PAIN SCREENING-Please answer Yes or No

- Do you suffer significantly from pain? YES _____ NO _____
- From a Scale of 1-10, What is your average daily pain _____
- Is your PCP or Pain Management Physician managing your pain? _____
- If you are seeing a Pain Management Physician please provide the name of the Physician _____

Functional Ability and Safety Assessment

REVIEW OF FUNCTIONAL ABILITY AND SAFETY

MOBILITY-Please check any medical equipment you use

Mobile Does No Need Assistance

Mobility Limited-Needs Assistance (with any of the below)

- Cane
- Walker
- Seated Walker
- Manual Wheel Chair
- Electric Wheel Chair
- Scooter Device

Toileting / Bathing

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

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 |

Transfer

Transfer Does Not Need Assistance

Transfer Ability Limited-Needs Assistance

- Mildly Impaired
- Moderately Impaired
- Severe Impaired

FEEDING

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

HEARING IMPAIRMENT

- No Limitations in Hearing
- Mild Limitations in Hearing
- Moderate Limitations in Hearing
- Severe Limitations in Hearing
____ Yes Using a Hearing Aid
____ No Not Using a Hearing

EXPLAIN _____

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

- Oxygen / Portable Oxygen
- Nebulizer (SVN Machine)
- CPAP Device
- Catheters
- Other _____

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 () MD () DO () NP () PA Print Providers Name _____ Date of Service _____