Medicare Preventative

Patients Name:

Date of Birth:

Today's Date:

Advanced Directives

Do you have a Durable Power of Attorney for healthcare?

Yes No

Do you have a Living Will?

Yes No

Would you like more information about a living will and durable power of attorney?

Yes No

Pain

On a scale of 1-10 are you having pain today?
(1 being the lowest and 10 the highest)
If yes where is the pain located?

When did you pain start?

Which best describes your pain? Circle

Aching Sharp
Burning Shooting
Discomfort Stabbing
Dull Throbbing
Gnawing Tingling
Piercing

Fall Risk

Have you fallen in the last year?

No Yes

If yes how many times have you fallen?

Did the fall(s) result in injury?

No Yes

If yes please describe

Exam Questionnaire

Quality of Life

Over the last 2 weeks how often have you been bothered by any of the following problems?
Little interest or pleasure in doing things (circle one)

Not at all Several Days
More than half the days Nearly every day

Feeling down, depressed or hopeless (circle one)

Not at all Several days
More than half the days Nearly everyday

Are you basically satisfied with your life?
Yes No
Have you dropped ,any of your activities and interests?
Yes No
Do you feel that life is empty?
Yes No
Do you often get bored?
Yes No
Are you in good spirits most of the time?
Yes No
Are you afraid that something bad is going to happen to you?
Yes No
Do you feel happy most of the time?
Yes No
Do you often feel helpless?
Yes No
Do you prefer to stay home rather than going out and doing new things?
Yes No
Do you feel that you have more problems with memory than most?
Yes No
Do you think it is wonderful to be alive now?
Yes No
Do you feel pretty worthless the way you are now?
Yes No
Do you feel full of energy?
Yes No
Do you feel that your situation is hopeless?
Yes No
Do you think that most people are better off than you are?
Yes No

Functional Ability, Safety, Home Environment

Are you able to climb stairs?
Yes No With difficulty

What do you have problems with?
Going up the stairs Going down the stairs

Are you able to exercise?
Yes No With difficulty

Are you able to get in and out of cars?
Yes No With difficulty

Are you able to kneel?
Yes No With difficulty

Are you able to put on socks and shoes?
Yes No With difficulty

Are you able to walk?
Yes No With difficulty

Are you able to walk 10 blocks?
Yes No With difficulty

Are you able to walk an unlimited distance?
Yes No With difficulty

Do you have a smoke detector in your home?
Yes No

Do you have firearms in your home?
Yes No

Are your firearms safely stored?
Yes No

Do you use a seatbelt in a vehicle?
Yes No

Do you have a carbon Monoxide Detector in you home?
Yes No

Nutrition

What type of diet do you follow?

Low Sodium	Low cholesterol
Dash Diet	Sugar free
Weight watchers	Healthy
Low fat	Vegan
Gluten free	Vegetarian
Mediterranean Diet	Other_____

Do you use a Calcium supplement?
Yes No

Do you take a daily multivitamin?
Yes No

Do you take a vitamin D supplement?
Yes No

Tobacco and Alcohol

Do you Smoke?
Yes No Former

Do you have second hand smoke exposure?
Yes No Former

Do you drink alcohol?
Yes No Former

Hwo frequently do you drink?
Daily Weekly Monthly

Yearly Occasionally Rarely

How much alcohol do you drink at one time?

When was your last drink?