Name:_____ Date: _____

Doctor:_____

DOB: _____

Hillcrest Internal Medicine
Annual Health Assessment 2019

Your insurance has asked us to provide them with the following information. Please answer the following questions **to the best of your ability.** This will allow your doctor screen for topics to review at your

Activities of Daily Living

Do you need assistance with…

1.	Bathing?	YES	NO
2.	Dressing or Undressing?	YES	NO
3.	Eating?	YES	NO
4.	Transferring from bed to chair and back?	YES	NO
5.	Do you have problems controlling urinary and fecal discharge?	YES	NO
6.	Using the toilet?	YES	NO
7.	Walking?	YES	NO

Fall Risk Screening

1.	Have you had a fall in the last 3 months?	YES	NO
2.	If yes how many times?_____ Were you injured?	YES	NO
3.	Are you on four or more medications?	YES	NO
4.	Do you have incontinence?	YES	NO
5.	Do you have visual impairment?	YES	NO
	A. Do you wear glasses or contacts?	YES	NO
6.	Do you have loss of function in a limb? (Impaired Mobility?)	YES	NO
7.	Do you have stairs or a bathtub? (Circle which one)	YES	NO
8.	Do you have a known diagnosis of dementia?	YES	NO
9.	Do you use a walker, cane, wheelchair or assist device? (circle)	YES	NO

Safety Precautions

1.	You should wear a helmet when riding a bike. Do you have concerns about this?	YES	NO
2.	You should exercise regularly. Do you have concerns about this?	YES	NO
3.	Do you have concerns about your eye sight?	YES	NO
4.	Do you have concerns about your hearing?	YES	NO
5.	Do you have concerns about climbing stairs?	YES	NO

SOCIAL HISTORY

Marital Status: _____

Current/Prior Occupation:_____ Are you retired? _____

Tobacco Use: ☐Never or ☐ ____ Packs a day since what age? _____ Quit? Approx Date_____

Alcoholic Beverage Use: How many drinks per week? _____

Pain Screening

Do you have acute (new) or chronic pain? YES NO

If yes, where is your pain?_____

On a scale of 0 to 10,(0 being "no pain" and 10 being "worst pain imaginable") what is your pain level?____

What treatment or medication do you use for pain?_____

In the past, how much relief has pain medication provided? (0%, 25%, 50%, 75%, 100%) _____

Check the following if they are affected by pain:

Bathing/Dressing☐ Mood☐ Walking Ability☐ Employment☐ Housework☐ Sleep☐

Relationships with others☐ Enjoyment of life☐ Transportation☐ Toileting☐ Food Preparation☐

FAMILY and HOME ENVIRONMENT

Living With: ☐Spouse ☐Child ☐Caregiver ☐Alone ☐Skilled Facility ☐ Other_____

Transportation: ☐Self ☐Depends on spouse ☐Depends on children ☐Depends on caregiver ☐Other _____

Advanced Directive? ☐Yes ☐No (If YES, does your doctor have a copy? ☐Yes ☐No)

Do you wear dentures? ☐Yes ☐No (are they removable ? ☐Yes ☐No)

Depression Screening

Please mark an "X" in the box that applies to each feeling:

Major Depression Inventory

How much of the time have you:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or have let yourself or family down				
Trouble concentrating on things, such as reading or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite-feeling fidgety more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way?				

Health Maintenance/Screening Schedule: Please list when you remember having this done last:

- Bone Density _____
- Cholesterol Test _____
- Colorectal Cancer Screening (colonoscopy or stool cards) _____
- Diabetic Screening Eye Exam or Glaucoma Test _____
- Flu Shot _____
- Mammogram or Prostate Exam _____
- Pneumonia Shot/Vaccine _____
- Shingles Shot/Vaccine _____
- Eye Exam (and with who) _____

Medications and Supplements:

_____

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