Family First Health Care
Capac - Armada

Date:_____/_____/_____

Annual Medicare Wellness Form

Name: DOB:

Health and Pain Assement

How would you rate your overall health? ***[ ] Excellent [ ] Very Good [ ]Good [ ] Fair [ ] Poor [ ] Very Poor***

Please rate your pain on a scale of 0-10 with 10 being the worst: _____

Location of pain: _____

Are you physically active?

Type of activity? _____

How many days of the week do you involve yourself with activity? _____

How would you rate your diet?

[ ]Very Healthy [ ] Moderately [ ] Healthy [ ] Moderately [ ] Poor [ ] Very Poor

Activities of Daily Living

Do you need assistance with grocery shopping and/or preparing meals? ***[ ] Yes [ ] No***

Do you need assistance with housework , i.e., washing dishes, vacumming, ect.? [***] Yes [ ] No***

Do you need help bathing or dressing? ***[ ] Yes [ ] No***

Can you handle your own money without help? ***[ ] Yes [ ] No***

Do you drive? ***[ ] Yes [ ] No***

Safety & Functional Mobility

Do you use hand rails when using the stairs? **[ ] Yes [ ] No**

Do you have good lighting in your home? **[ ] Yes [ ] No**

Do you have loose throw rugs in your home? **[ ] Yes [ ] No**

Do you have difficulty getting out of chairs and/or out of bed? **[ ] Yes [ ] No**

Do you hold onto walls or furniture when you walk? **[ ] Yes [ ] No**

Are you afraid of falling? **[ ] Yes [ ]No**

Have you fallen within the past year? **[ ] Yes [ ] No** **If yes**, how many times:_____

Check all devices used: **[ ] Wheel Chair [ ] Walker [ ] Cane**

Do you have trouble making it to the bathroom on time? **[ ] Yes [ ]No**

Hearing, Vision, Dental

Do you have any visual impairments or use glasses or contacts? ***[ ] Yes [ ] No***

When was your last eye exam?_____

Do you have any hearing impairments? ***[ ] Yes [ ] No*** Do you use hearing aids? ***[ ] Yes [ ] No***

When was your last dental visit?_____

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Psychosocial Assessment

Do you consume alcohol? ***[ ] Yes [ ] No***

If yes, how many drinks per day?_____How many per week?_____

Do you use tobacco? ***[ ] Yes [ ] No***

Do you use street drugs or medications not prescribed to you? ***[ ] Yes [ ] No***

Do you have a history of IV drug use?_____

Legal

Do you have an Advanced Medical Directive ***[ ] Yes [ ] No***

Does your doctor have a copy of your Advanced Medical Directive? ***[ ] Yes [ ] No***

Do you have a Durable Power of Attorney? ***[ ] Yes [ ] No***

Does your doctor have a copy of your Durable Power of Attorney? ***[ ] Yes [ ] No***

Specialist involved with your care:

Please list the name of any specialist you see and the Month/Year of last visit:

_____

_____

_____

_____

Medications:

Name of Med	Strength	How many times a day

Do you have a history of Abdominal Aortic Aneurysm (AAA)? Y [ ] N [ ]

Patient Name: _____ DOB: _____ Date: _____

Provider: _____

Fall Risk Screening

Instructions: Circle "Yes" or "No" for each statement below			
		Statement	**Why it matters**
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I used to or have been advised to use a cane or a walker to get around safely.	People who have been advised to use a cane or a walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.

Total Score:

Add up the number of points for each "yes" answer. If your score is ≥4 points, you may be at risk for falling.

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. J Safety Res; 2011: 42(6)493-499).

Patient Health Questionnaire and General Anxiety Disorder
(PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	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
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

BLADDER CONTROL

Bladder Control

Assessment Tool

How do I use this Assessment?

Read the questions on both pages and answer them based on the last month. Share your completed assessment with your health care provider. Your answers on this assessment may help you to measure your symptoms and how much they may bother you.

Symptom Questions

Answer each question below on a scale from zero to five. The symptom questions may then be added to get a score from 0 (no symptoms) to 25 (most severe symptoms). The higher your score for these questions, the more severe your symptoms may be.

SYMPTOM QUESTIONS	Not at all	Occasionally	About once a day	About three times a day	About half the time	Almost always	SCORE
Urgency *How often do you have a strong, sudden urge to pass urine where you fear you may leak urine?*	*0**	*1*	*2*	*3*	*4*	*5*	
Urgency Incontinence *How often have you leaked urine?*	*0*	*1*	*2*	*3*	*4*	*5*	
	None	**Drops**	**1 Tea-spoon**	**1 Table-spoon**	**¼ cup**	**Entire bladder**	
Incontinence *How much urine do you think leaks?*	*0*	*1*	*2*	*3*	*4*	*5*	
	1-6 times	**7-8 times**	**9-10 times**	**11-12 times**	**13-14 times**	**15 or more times**	
Daytime Frequency *How often do you pass urine during the day?*	*0*	*1*	*2*	*3*	*4*	*5*	
	None	**1 time**	**2 times**	**3 times**	**4 times**	**5 times or more**	
Nighttime Frequency *How many times did you wake up to pass urine during the night?*	*0*	*1*	*2*	*3*	*4*	*5*	
TOTAL SYMPTOM SCORE					Add score from right column to find total score.		

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Quality of Life Questions

For the quality of life questions below, please circle the response that best describes how bothered you have felt over the last month. These questions **do not** need to be added. This section may help show how your symptoms impact your life.

QUALITY OF LIFE QUESTIONS How much does this bother you:	I am not bothered at all					I am bothered a great deal
Activities *My bladder control has limited activities with friends and family.*	*0*	*1*	*2*	*3*	*4*	*5*
Work *My ability to work or volunteer outside the home has been limited by my bladder control.*	*0*	*1*	*2*	*3*	*4*	*5*
Sleep *Bladder control is keeping me from getting a good night's sleep.*	*0*	*1*	*2*	*3*	*4*	*5*
Exercise *I have had to limit exercise or physical activity due to my bladder control.*	*0*	*1*	*2*	*3*	*4*	*5*
Travel *Bladder control keeps me from traveling, taking trips, or using public transit.*	*0*	*1*	*2*	*3*	*4*	*5*
Feelings *I am embarrassed because of my bladder control.*	*0*	*1*	*2*	*3*	*4*	*5*

The better your health care provider knows the level and impact of your symptoms and quality of life, the better he or she can help you manage them. Even if you are not bothered much about mild symptoms, you and your health care provider may want to discuss what treatment options are available to you.

Disclaimer

This information is not a tool for self-diagnosis or a substitute for professional medical advice. It is not to be used or relied on for that purpose. Please talk to your urologist or health care provider about your health concerns. Always talk to a health care provider before you start or stop any treatments, including medications.

For more information, visit **UrologyHealth.org/Download** or call 800-828-7866.

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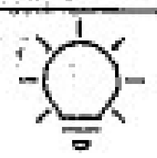
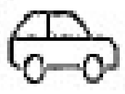
Social Determinants of Health Survey

Patient Name: _____ Birthdate: _____/_____/_____

Today's Date: _____/_____/_____

To better meet the health needs of the patients at our practice, we have created a list of questions that we are asking each patient to complete on a yearly basis. Your answers will help us to know if you have needs outside of your general health that could be affecting your wellbeing.

	Question			
	Do you ever eat less food than you feel you should because there is not enough food?	Yes	No	N/A
	In the past 12 months, was there a time when you needed to see a doctor but could not because it cost too much?	Yes	No	N/A
	Do you have a hard time finding work or another steady source of income?	Yes	No	N/A
	Are you worried that in the next few months, you may not have safe housing?	Yes	No	N/A
	In the past year, have you had a hard time paying your utility company bills?	Yes	No	N/A
	Does caring for children, family or friends make it hard for you to take care of your own needs?	Yes	No	N/A
	Do you think completing more education or training would be helpful to you?	Yes	No	N/A
	Do you ever have trouble getting to work, school, the store, and/or appointments because you don't have a way to get there?	Yes	No	N/A
	Do you ever feel unsafe in your home or neighborhood?	Yes	No	N/A
	In the past month, did poor physical or mental health keep you from doing your usual activities?	Yes	No	N/A
?	Would you like assistance with any of these needs?	Yes	No	N/A
!	Are any of your needs urgent? Example: I don't have food or a place to sleep tonight?	Yes	No	N/A