**Patients Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE CHECK “YES” TO ANY CURRENT HEALTH ISSUES (If no leave blank)**

Fatigue/Change in energy O Yes Unexplained Weight Loss O Yes Tingling/numbness O Yes

Change in vision O Yes Excessive Thirst O Yes Shortness of breath \_\_ O Yes

Cough O Yes Racing/ irregular heartbeat O Yes Chest pain O Yes

Swelling of ankles O Yes Pains in leg while walking O Yes Abdominal pain O Yes

Heartburn or Indigestion O Yes Black stool/blood in stool O Yes Difficulty Swallowing O Yes

Abnormal vaginal discharge O Yes Blood in Urine O Yes Fainting or Passing out O Yes

Burning/pain with urination O Yes Swollen Joints O Yes

Decreased force of urine stream O Yes

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the last 2 weeks, how often have you been bothered by any of the following problems? (use “X”) to indicate your answer) | Not at all 0 | Several days 1 | More than half the days 2 | Nearly every day  3 |
| 1. Little interest or pleasure in doing things |  |  |  |  |
| 2. Feeling down, depressed, or hopeless |  |  |  |  |
| 3. Trouble falling or staying asleep, or sleeping too much |  |  |  |  |
| 4. Feeling tired or having little energy |  |  |  |  |
| 5. Poor appetite or overeating |  |  |  |  |
| 6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down |  |  |  |  |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television. |  |  |  |  |
| 8. Moving or speaking so slow that other people could have noticed; or the opposite, be so fidgety or restless that you have been moving around a lot more than usual |  |  |  |  |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way |  |  |  |  |

­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Do you skip doses or try to “Stretch out” your medictions due to concerns about the cost? O Yes/ O No
2. Are you eating less than you feel you should because there wasn’t enough money for food? O Yes/ O No
3. Do you skip healthcare appointments because you don’t have a way to get there? O Yes/ O No
4. Are you having trouble paying your heat or electric bill? O Yes/ O No
5. Are you worried that in the next 2 months you may not have stable housing? O Yes/ O No
6. If you checked yes to any boxes above, would you like to receive assistance with O Yes / O No

any of these needs?

If you are **50 years of age or older**, please select a response for any falls within the past year.

Have you fallen in the last year O Yes O No

One fall with injury in the past year O Yes O No

Two or more falls with injury in the past year O Yes O No

One fall without injury in the past year O Yes O No

Two or more falls without injury in the past year O Yes O No

**If you are diabetic** when was your last eye exam: Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you need prescription refills: Y / N Which Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor/ Nurse Practitioner signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_