**Lifetime values your privacy and will keep your answers confidential.**

**This can be used for the welcome to Medicare Physical or Annual Physical**

**If you don't want to answer a question, feel free to leave it blank.**

**Name:**__________________________ **Date:** ________________________

Please list current providers regularly involved in your medical care other than Lifetime Family and Urgent Care.

Do you have a signed Living Will? Yes No Don't know

Do you have an up-to-date Durable Power of Attorney for health care?

Yes No Don't know

How would you describe your general health?

Excellent Very Good Good Fair Poor

On average, how many days per week do you exercise, like gardening or going for a brisk walk?

0 1 2 3 4 5 6 7 Don't know

On average, how many minutes do you exercise at this level each day? _________________

Do you eat fruits and vegetables every day? Yes No

Do you eat 2 or more meals every day? Yes No

How would you describe the condition of your mouth and teeth, including false teeth or dentures?

Excellent Very Good Good Fair Poor

Do you always fasten your seat belt when you're in a car? Yes No I don't ride in a car

Do you have working smoke detectors on all floors of your home? Yes No

Are all the stairs at home well-lit and do they have handrails? Yes No Doesn't apply to me

During the past year, have you had any major changes in your life, good or bad? Yes No

If YES, please explain:

How often is stress a problem for you in handling such things as your health, finances, family or social relationships, or work? Never Rarely Sometimes Often Always



**Continued on next page**

Over the last 2 weeks, how often have you been bothered by the following problems?

Feeling anxious, nervous, or on edge?

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

Not being able to control or stop worrying?

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

Over the last 12 months, how often have you felt Sad or Depressed?

Never    Rarely    Sometimes    Often    Always

How often do you get the social and emotional support you need?

Always    Often    Sometimes    Rarely    Never

How often did you have one drink containing alcohol in the last year?

Never [0]    Monthly or less [1]    2 to 4 times a month [2]

2 to 3 times a week [3]    4 or more times a week [4]

How many drinks containing alcohol did you have on a typical day when you were drinking in the last year?

I don't drink alcohol    1 or 2 [0]    3 or 4 [1]    5 or 6 [2]    7 to 9 [3]    10 or more [4]

How often did you have 6 drinks or more on one occasion in the last year?

Never [0]    Less than monthly [1]    Monthly [2]    Weekly [3]    Daily or almost daily [4]

How often have you used marijuana in the last year?

Never [0]    Less than monthly [1]    Monthly [2]    Weekly [3]    Daily or almost daily [4]

How often have you used recreational drugs (such as heroin, cocaine, or methamphetamine) or used a prescription medicine (such as oxycodone, hydrocodone, or methadone) for non-medical reasons in the last year?

Never [0]    Less than monthly [1]    Monthly [2]    Weekly [3]    Daily or almost daily [4]

Have you ever used tobacco (smoke, chew, or e-cigarettes) or other vapor product?    Yes    No

If YES:

Have you smoked 100 cigarettes or more in your lifetime?    Yes    No

**Continued on next page**

| **Over the** <u>**last 2 weeks**</u>**, how often have you been bothered by any of the following problems?** *(Use "✔" to indicate your answer")* | **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 |

**Column totals:** ____ + ____ + ____ + ____

= ***Total Score*** _____

***Do you have any suicidal thoughts?*** ***Yes, No***

***If yes, please inform us*** ______________________________________________



**Continued on next page**

Have you had sex with a new partner or partners in the last year?

Yes No Prefer not to answer

If YES, did you use condoms? Always Sometimes Never

Have you fallen 2 or more times in the past 12 months? Yes No

Are you here today because of a fall? Yes No

Do you have any problems with walking or balance? Yes No

Do you often ask people to repeat what they've said?
Or do you notice that you have difficulty hearing people? Yes No

Do you or does anyone in your family notice that you are having memory problems that interfere with your life? Yes No

Is urination or leaking urine causing any problems with your daily activities or sleep? Yes No

How many days a week does pain or fatigue keep you from doing things you like to do?

0 1-2 days each week 3-4 days each week 5 or more days each week

Do you need help with any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Preparing meals | Yes | No | Managing money | Yes | No |
| Taking medicine | Yes | No | Transportation | Yes | No |
| Doing housework | Yes | No | Making and keeping appointments | Yes | No |
| Shopping for food | Yes | No | | | |

Do you need help with any of these?

| | | | | | |
|---|---|---|---|---|---|
| Dressing | Yes | No | Using the toilet | Yes | No |
| Getting in and out of chairs | Yes | No | Eating | Yes | No |
| Bathing | Yes | No | Walking | Yes | No |



**Continued on next page**

## Medical and Surgical History

Please list any major illnesses, injuries, or conditions that you haven't told us about in the past.

None

Please list any major surgeries performed that you haven't told us about in the past.
List each one and the approximate year.

None

## Personal and Family History (those related to you by blood)

Do you have a parent, brother, or sister who had an abdominal aortic aneurysm?
Yes No Don't know

Do you have a personal or family history of breast cancer? Yes No Don't know
If YES, please describe (i.e.: you, which family member):

Did any of the following family members develop heart disease? Check all that apply.
Before age 55: father, brother, or son None before age 55 Don't know

Before age 60: mother, sister, or daughter None before age 60 Don't know

Have you ever had Crohn's disease, ulcerative colitis, colon polyps, or colon cancer?
Yes No

Have you had a mother, father, sister, brother, daughter, or son diagnosed with the following?

Colon cancer: No Yes – at what age:_____ Don't know

Colon polyps: No Yes – at what age:_____ Don't know

Have you had a grandparent, aunt, uncle, niece, or nephew diagnosed with the following?

Colon cancer: No Yes – at what age:_____ Don't know

Do you have a signed Living Will? Yes No Don't know

Do you have an up-to-date Durable Power of Attorney for health care?

Patient's Signature ______________________ Date _________________________