Date:

CABOT MEDICAL CARE HEALTH HISTORY- ADULTMEDICARE WELLNESS

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

HEALTH HABITS AND PERSONAL SAFETY						
ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
General Health	In general would you say your health is: Excellent, Very Good, Good , Fair or Poor					
	In general would you say your dental health is: Excellent, Very Good, Good , Fair or Poor					
	Please select your current pain level (0-No pain-10 in severe pain) 0 1 2 3 4 5 6 7 8 9 10					
10ADL	Do you require help with any of the following activities? (please circle all that apply) Bathing, Dressing, Toilet Use, Transferring, Urine/Bowel Incontinence, Eating, Shopping, Housekeeping, Handling Finances, Taking Medications					
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you wear your seatbelt?				☐ Yes	☐ No
	Do you have throw rugs in your home?				☐ Yes	☐ No
	Does your home have poor lighting?				☐ Yes	☐ No
	Do you have a slip resistant mat in Bathtub and/or shower?				☐ Yes	☐ No
	Do you have grab bars in your bathroom?				☐ Yes	☐ No
	Do you have functioning smoke alarms in your home?				☐ Yes	☐ No
	Do you have handrails on stairs and steps at your home?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?				☐ Yes	☐ No

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Allergies to medications	
Name the Drug	Reaction You Had

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

List any medical problems that other doctors have diagnosed				
Do you currently have?				
Pacemaker ☐ Yes ☐ No	Defibrillator ☐ Yes ☐ No	Pain Stimulator ☐ Yes ☐ No	Pain Pump ☐ Yes ☐ No	Allergy to IV Contrast ☐ Yes ☐ No
Have you ever had a blood transfusion?			☐ Yes	☐ No
Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio				

Other hospitalizations		
Year	Reason	Hospital

Please turn to next page

		Date/Year		Date/Year
Immunizations and dates:	☐ Tetanus		☐ Pneumonia	
	☐ Hepatitis		☐ Chickenpox	
	☐ Influenza		☐ MMR *Measles, Mumps, Rubella*	
	☐ Shingles		☐ Other:	

	Date/Year		Date/Year		Date/Year	
Preventative Screenings and dates:	☐ Aortic Ultrasound		☐ Dilated Eye Exam/Eye Exam		☐ Other:	
	☐ Bone Density Test		☐ Mammogram			
	☐ Colonoscopy		☐ Pap			
	☐ Dental Exam		☐ Prostate Screening (PSA)			

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you fell anxious often?	☐ Yes	☐ No
Are you unable to control or stop worrying?	☐ Yes	☐ No
Do you often feel stress about your health, finances, family, relationships or work?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you get the social and emotional support you need?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

List any other doctors who follow your care and why they see you:

Do you have an Advance Directive or Living Will?	☐	Yes	☐	No
Would you like information on the preparation of these?	☐	Yes	☐	No

Please turn to next page

Surgeries		
Year	Reason	Hospital

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

Tobacco	Do you use tobacco?				☐ Yes	☐ No	
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola			
	# of cups/cans per day?						
Alcohol	Do you drink alcohol?				☐ Yes	☐ No	
	If yes, what kind?						
	Have you ever felt you should cut down on how much you drink?				☐ Yes	☐ No	
	Have people annoyed you by criticizing your drinking?				☐ Yes	☐ No	
	Have you ever felt bad about your drinking?				☐ Yes	☐ No	
	Have you ever had a drink first thing in the morning to steady your nerves or to get				☐ Yes	☐ No	
	rid of a hangover (eye-opener)?						
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No	
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No	

Arkansas Central Primary Care

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Name: _____ Date of Birth: _____ Today's Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Circle 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

For Office Coding: __0__ + _____ + _____ + _____**=Total Score:** _____

Would you agree to see a counselor? Yes ☐ **No** ☐

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

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

Arkansas Central Primary Care
Fall Risk Assessment

Name: _____ Date of Birth: _____ Today's Date: _____

(Circle your answer)

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 use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker make already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking at home.	Unsteadiness or needing support while walking are signs f 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 my hands to stand up 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 _____		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

Your doctor may suggest:

- Having other medical tests
- Changing your medications
- Consulting a specialist
- Seeing a physical therapist
- Attending a fall prevention program