Name: _____ Date of birth: _____ Today's date: _____

Please complete this checklist before seeing your doctor. Your responses will help you receive the best healthcare possible.

1. What is your age?

□ 65-69 □ 70-79 □ 80 or older

2. Are you a male or female?

□ Male □ Female

3. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

□ Not at all
□ Slightly
□ Moderately
□ Quite a bit
□ Extremely

4. During the **past four weeks**, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

□ Not at all
□ Slightly
□ Moderately
□ Quite a bit
□ Extremely

5. During the **past four weeks**, how much pain in your body have you had?

□ No pain
□ Very mild pain
□ Mild pain
□ Moderate pain
□ Severe pain

6. During the **past four weeks**, was someone available to help you if you needed and wanted help?

□ Yes, as much as I wanted
□ Yes, quite a bit
□ Yes, some
□ Yes, a little
□ No, not at all
□ No assistance needed

7. During the **past four weeks**, what was the hardest level of physical activity you could do for at least **two minutes**?

□ Very heavy
□ Heavy
□ Moderate
□ Light
□ Very light

8. In the **past seven days**, how many days did you exercise?

_____days

9. In the **past seven days**, how many minutes per day did you exercise?

_____minutes

10. Can you go shopping for groceries or clothes without someone's help?

□ Yes □ No

11. Can you prepare your own meals?

□ Yes □ No

12. Because of health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

□ Yes □ No

13. Can you handle your own money without help?

□ Yes □ No

14. Each night, how many hours of sleep do you usually get?

_____ hours

15. Do you snore or has anyone told you that you snore?

□ Yes □ No

16. Do you always fasten your seat belt when you are in a car?

□ Yes □ No

17. Do you drive after drinking alcohol or ride with a driver who has been drinking?

□ Yes □ No

18. During the **past four weeks**, how many drinks of wine, beer or other alcoholic beverages did you have?

□ 10 or more drinks per week
□ 6 - 9 drinks per week
□ 2 - 5 drinks per week
□ 1 drink or less per week
□ No alcohol at all

19. How often during the **past four weeks**, have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up	□	□	□	□	□
Sexual problems	□	□	□	□	□
Trouble eating well	□	□	□	□	□
Teeth or denture problems	□	□	□	□	□
Problems using the telephone	□	□	□	□	□
Tiredness or fatigue	□	□	□	□	□

20. Are you a smoker?

□ No
□ Yes
□ Yes, but I'm not ready to quit

21. During the **past four weeks**, how would you rate your health in general?

□ Excellent
□ Very good
□ Good
□ Fair
□ Poor

22. What is your race? (**Check all that apply**)

□ American Indian or Alaskan Native
□ Asian
□ Black or African American
□ Hispanic or Latino origin
□ White
□ Other

Patient Signature _____ Date/Time _____

Signature of Authorized Person _____ Date/Time _____

Relationship to patient _____

Healthcare Provider Signature _____ Date/Time _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

Patient Current Physician List

Patient Name: _____

Date of Birth: _____

Please list all of the physicians that you are currently seeing.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Provider signature: _____

Date: _____ Time: _____