guardian

The Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date of Visit:** _____

Practice Name: ORLANDO INTERNAL MEDICINE

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

	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 hurting yourself in some way.	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

guardian

FALL RISK ASSESSMENT

Instructions: In order to gain greater insight into potential risks for falls, for this patient, please complete the Personal Risk Factors Prevention Checklist. Select the answers below.

Personal Risk Fall Prevention Checklist

1. **Have you fallen before or been injured by a fall?**

   Yes No

2. **Do you feel weaker than you used to or have less strength in your arms and legs?**

   Yes No

3. **Have you stopped doing daily activities or avoided exercise because you're afraid of falling?**

   Yes No

4. **Do you experience incontinence?**

   Yes No

5. **Has your hand strength decreased?**

   Yes No

6. **Has your eyesight diminished or do you have trouble seeing depth or seeing at night?**

   Yes No

7. **Do you feel dizzy when you stand up?**

   Yes No

8. **Have you experienced hearing loss?**

   Yes No

9. Do you have foot ulcers, bunions, hammertoes or callouses that hurt or cause you to adjust your steps?

Yes No

10. Do you feel unsteady on your feet or shuffle when you walk?

Yes No

GUARDIAN PRE ANNUAL WELLNESS EXAM

PATIENT SELF-ADMINISTERED HEALTH RISK ASSESSMENT (HRA)

This assessment is designed to provide us with some important health and health related information. The information that we receive in the assessment helps us understand your unique health and health related problems, and develop appropriate measures to assist you in maintaining our health and well-being. We ask that you please complete all sections of the assessment. The information you provide is part of your personal health information and is held in strict confidence and privacy.

Patient Name : _____ **Date of Birth** : _____

Gender : _____ **Medicare Number** : _____

Date HRA Initiated : _____

1. Type of Health Risk Assessment

○ Initial Health Risk Assessment

○ Subsequent Health Risk

○ Other, please specify

_____

Physical Health Rating

1. In general, would you say your health is?

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

2. During the **past 4 weeks**, to what extent has your physical health interfered with your normal social activities with family, friends, neighbors, or other groups?

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

3. How confident are you that you can control and manage your health problems?

○ Very ○ Confident ○ Somewhat ○ Somewhat Unconfident ○ Not at all

Pain

1. How much bodily pain have you generally had during the **past 4 weeks**?

○ None ○ Very Mild ○ Mild ○ Moderate ○ Severe ○ Very Severe

2. When you had pain during the **past 4 weeks,** how long did it last?

○ Did not have any pain ○ A few minutes ○ Several minutes to an hour

○ Several hours ○ A day or two ○ More than 2 days

Activities of Daily Living

1. Because of a health or physical problem, do you have any difficulty doing the following activities **without special equipment or help from another person**?

	No, I do not have difficulty	Yes, I have difficulty	I am unable to do this activity
Bathing	○	○	○
Dressing	○	○	○
Eating	○	○	○
Getting in or out of a chair	○	○	○
Walking	○	○	○
Using the Toilet	○	○	○
Preparing Meals	○	○	○
Taking Medications	○	○	○

Problems with Medications

1. Below is a list of problems that people sometimes have with their medicines. Please check how difficult it is for you to do each of the following.

	Not Hard at All	Somewhat Hard	Very Hard
Open or close the medicine bottle	○	○	○
Read the print on the bottle	○	○	○
Remember to take the pills	○	○	○
Take so many pills at the same time	○	○	○

2. Do you ever skip medication because you cannot afford it?

○ Yes ○ No

FALLS AND FEAR OF FALLING

History of Falls

1. Have you experienced a fall during the **past 12 months**?

○ Yes ○ No

2. During the **past 12 months** have you had a problem with balance or walking?

○ Yes ○ No

Fear of Falling

3. For each of the following activities, please select the opinion closest to your own to show how concerned you are that you might fall if you did this activity.

	Not at all Concerned	Somewhat Concerned	Fairly Concerned	Very Concerned
Cleaning the house	○	○	○	○
Getting dressed or undressed	○	○	○	○
Taking a bath or shower	○	○	○	○
Getting in and out of a chair	○	○	○	○
Reaching for something above your head or on the ground	○	○	○	○
Getting up and down stairs	○	○	○	○
Going out to a social event	○	○	○	○

1. **Home Safety**

	Yes	No
Do you have working smoke detectors on all floors of your home?	○	○
Are the floors in	○	○

your home free of clutter?		
Are you confident that the lighting in your home is adequate?	○	○
Can you easily reach the things you use often?	○	○
Are emergency contact numbers easily readable and available?	○	○

HEALTH HABITS

NUTRITION

For the following statements, please indicate whether or not each statement applies to you.

1. I eat fewer than 2 meals a day.

○ Yes ○ No

2. I eat few fruits or vegetables.

○ Yes ○ No

3. I have 3 or more drinks of beer, liquor or wine almost every day.

○ Yes ○ No

4. I have tooth or mouth problems that make it hard for me to eat.

○ Yes ○ No

5. I don't always have enough money to buy the food I need.

○ Yes ○ No

6. I eat alone most of the time.

○ Yes ○ No

7. I take 3 or more different prescribed or over-the-counter drugs a day.

○ Yes ○ No

8. Without wanting to, I have lost or gained 10 pounds in the last 6 months.

○ Yes ○ No

9. I am not always physically able to shop, cook and/or feed myself.

○ Yes ○ No

Physical Activity

1. In an average week, how many times do you engage in physical activity for at least 20 minutes (exercise or work which is hard enough to make you breath heavily and make your heart beat faster). Examples include running and brisk walking.

○ Less than 1 time per week ○ 1 to 2 times per week

○ 3 times per week ○ 4 or more times per week

Tobacco Use

2. How would you describe your cigarette smoking habits?

○ Still Smoke ○ Used to Smoke ○ Never Smoked

3. If you used to smoke, how many years has it been since you smoked cigarettes on a fairly regular basis?

○ Less than 2 years ○ Over 2 years

Alcohol and other substance abuse

4. Do you have two or more drinks of beer, wine, or liquor almost every day?

○ Yes ○ No

5. Have any of your friends, relatives, or health professionals expressed concern about your drinking or suggest that you cut down?

○ Yes ○ No

6. Have you ever felt guilt or remorse after drinking?

○ Yes ○ No

7. In the **past 12 months** have you used drugs other than those required for medical reasons?

○ Yes ○ No

Emotional Well-being

1. Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Yes	No
Little interest or pleasure in doing things	○	○
Feeling down, depressed or hopeless	○	○

Memory and Cognitive Functioning

1. During the **past 12 months,** have you experienced confusion or memory loss?

○ Yes ○ No

2. In the **past 12 months,** how often have you given up household activities or chores you used to do because of confusion or memory loss?

○ Never ○ Sometimes ○ Always

Hearing

1. Have you ever had deafness or trouble hearing with one or both ears?

○ Yes ○ No

2. Without a hearing aid, can you usually hear and understand what a person says without seeing his/her face if that person whispers to your from across the room?

○ Yes ○ No

3. Without a hearing aid, can you usually hear and understand what a person says without seeing his/her face if that person talks in a normal voice to you from across the room?

○ Yes ○ No

Vision

1. At the present time, would you say your eyesight using both eyes (with glasses or contact lenses, if you wear them) is:

○ Excellent ○ Good ○ Fair ○ Poor ○ Completely Blind

2. How much of the time do you worry about your eyesight?

○ None of the time ○ A little of the ○ Some of the ○ Most of the time

○ All of the time

3. How much pain or discomfort have you had in and around your eyes (for example, burning, itching aching)? Would you say it is:

○ None ○ Mild ○ Moderate ○ Severe ○ Very severe

THANK YOU FOR COMPLETING THIS FORM

NAME OF ALL YOUR DOCTORS:	SPECIALTY

NAME OF ALL MEDICATIONS	DOSE