NAME: ___________________________________ **DOB:** _____________ **DATE:** ___________

Medicare Health Assessment Form

Overall, how would you describe your health? □ Excellent □ Very Good □ Good □ Poor □ Fair

Have you lost or gained 10 lbs or more in the last six months without meaning to? □ Yes □ No

Do you have concerns about your hearing? □ Yes □ No

In the past 12 months, have you experienced 2 or more falls? □ Yes □ No

Have you injured yourself in a fall in the past 12 months? □ Yes □ No

□ No changes in past 12 months **MEDICAL HISTORY**

ILLNESS	YES/NO	YEAR of START	ILLNESS	YES/NO	YEAR of START
High Blood Pressure	Y / N		Diabetes	Y / N	
Heart Disease	Y / N		Obesity	Y / N	
Bone or Joint Disease	Y / N		Eye/Vision Problems	Y / N	
Abnormal heart rhythm Pacemaker or AICD implant	Y / N Y / N		Neurologic disorder (i.e., dementia, Parkinson)	Y / N	
Kidney disease Dialysis	Y / N Y / N		Depression or other mood disorders	Y / N	
Stroke or mini-stroke	Y / N		Cancer:	Y / N	
Liver Disease	Y / N		Prostate:	Y / N	
Lung Disease	Y / N		Breast	Y / N	
Blood clots	Y / N		Colon/Rectal:	Y / N	
Digestive Problems	Y / N		Skin	Y / N	
Urine Leakage	Y / N		Other cancer	Y / N	

OTHER: ____

□ No changes in past 12 months **HOSPITALIZATION LAST 12 MONTHS**

Date	Name of Hosp	Reason	Date	Name of Hosp	Reason

□ No changes in past 12 months **PAST SURGERIES**

Date	Surgery / Procedure

NAME: ______________________________ **DOB:** ____________ **DATE:** __________

☐ No changes in past 12 months	FAMILY MEDICAL HISTORY				
ILLNESS	**FATHER**	**MOTHER**	**BROTHER(S)**	**SISTER(S**	**CHILD(REN)**
High Blood Pressure					
Heart Disease					
Stroke or mini-stroke					
Kidney disease Dialysis Y/N					
Liver Disease					
Glaucoma					
Osteoporosis					
Joint Problems					
Digestive Problems					
Diabetes					
Neurologic Disorders					
Depression or other mood disorders					
Breast Cancer: Colon/Rectal Cancer: Other Cancer:					

☐ No changes in past 12 months	ALLERGY LIST		
Name Medication or Food	**Type of Reaction**	**Name Medication or Food**	**Type of Reaction**
1.		4.	
2.		5.	
3.		6.	

☐ No changes in past 12 months	MEDICATIONS AND SUPPLEMENTS		
NAME OF MEDICATION or VITAMIN or HERB	**DOSE**	**HOW OFTEN**	**REASON TAKING**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

☐ No changes in past 12 months	DOCTORS and PROVIDERS INVOLVED IN YOUR CARE
Specialty	**Name**
Primary Care	
Cardiologist/Heart	
Pulmonologist/Lungs	
Renal/Kidney	
Oncology/Cancer	
Psychologist/Therapist	
Other:	
Ophthalmologist	

NAME: ___________________________________ **DOB:** _____________ **DATE:** ___________

□ No changes in past 12 months **ADVANCED DIRECTIVES:**			***Office Only**
Do you have any of the below?	**Yes**	**No**	***Copy on File**
Medical HealthCare Power of Attorney If yes, name of designated POA & contact number: ____			Y/N
Living Will			Y/N
Do Not Resuscitate form (DNR) (Bright Yellow Form) *if expires – date:____________________			Y/N
MOST (Medical Order Scope of Treatment) (Bright Pink form) *expires on:___________________			Y/N
Other? Please specify, _______________________________________			Y/N
Would you like to have a conversation today about your wishes for end-of-life care?			Y/N

1. Do you smoke or use smokeless tobacco products?
   - □ NO, not any more   □ YES, every day
   - □ NO, never have   □ YES, some days

   If YES, what kind of tobacco product do you use? ____________________
   How much each day? ________________ per day   For How many years?________________

   If quit, how many years ago? ____________
   What kind of support did you use:
   - □ None   □ Medication
   - □ Counseling   □ Nicotine patch or gum
   - □ Hypnosis   □ Other: ____________________

   Do you feel ready to quit?
   - □ Yes   □ No

   Do you have concerns about tobacco use in your household?
   - □ Yes   □ No

2. For MEN: How many times in the past 12 months, have you had 5 or more drinks in a day?
   - □ Never   □ Monthly   □ 4-6 times a week
   - □ Less than monthly   □ 2-3 times a week   □ Daily

3. For WOMEN: How many times in the past 12 months, have you had 4 or more drinks in a day?
   - □ Never   □ Monthly   □ 4-6 times a week
   - □ Less than monthly   □ 2-3 times a week   □ Daily

4. In the past 12 months did you smoke marijuana; use another street drug; or use prescription pain killers, stimulants or sedatives for a non-medical reason?
   - □ Yes   □ No

If yes what drugs did you use in the past 12 months?
- □ Amphetamines   □ Marijuana   □ Inhalants/Glue/Solvents
- □ Hallucinogens/LSD   □ Ecstasy   □ Methamphetamine
- □ Cocaine   □ Heroin   □ Other:____________

NAME: ________________________________ **DOB:** ____________ **DATE:** __________

□ No changes in past 12 months	**EXERCISE ASSESSMENT**	
I exercise: □ Not at all or rarely □ 1-2 days week □ 3-4 days week □ 5 or more days a week	**Type of exercise typically:** □ Not applicable- do not exercise □ Light (ex. stretching or slow walking) □ Moderate (ex. brisk walking) □ Heavy (ex. jogging or swimming) □ Very Heavy (ex. fast running or stair climbing)	**Duration of exercise**: □ ______ minutes □ 20-30 minutes □ 30-60 minutes
Do you participate in strength training > 2x a week? □ Yes □No		

□ No changes in past 12 months **HOME ENVIRONMENT**		
Do you live alone?	Yes	No
If NO, who do you live with?		
Where do you live? Check one of the answers below. □Home □Homeless/Shelter □Assisted Living □Nursing Home □Hospice □Other: ________________________________		
Are you concerned about your safety?	Yes	No
Do you have support from friends and family?	Yes	No
Are you concerned about your finances or ability to pay for your care or medications?	Yes	No
IF yes, please give more information.		
Do you have any other concerns of things that make it hard for you to take care of yourself?	Yes	No
IF yes, please give more information.		

Over the past two weeks, how often have you had little interest or pleasure in doing things?
□ (0) Not at all □ (1) Several days □ (2) More than half the days □ (3) Nearly everyday

In the past 2 weeks, how often have you felt down, depressed or hopeless?
□ (0) Not at all □ (1) Several days □ (2) More than half the days □ (3) Nearly everyday

Activities of Daily Living (ADLs)/Independent Activities of Daily Living (IADLs)
In the past 7 days have you needed help with any of the following activities?

Place a check mark next to the answer that best applies to you (one answer for each section in the boxes below).

	Yes	**No**			**Yes**	**No**
Preparing meals				Walking		
Taking medications				Dressing		
Doing housework				Bathing		
Shopping for food				Getting in/out of chairs		
Managing money				Eating		
Driving				Using the toilet		