CURRENT MEDICATIONS / STRENGTH / DOSAGE

_____
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CURRENT PHYSICIAN SPECIALIST:

_____
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_____
_____

****THE ABOVE INFORMATION IS REQUIRED PER MEDICARE GUIDELINES

Name: _____ **DOB: _____**

PCP: _____ **Date: _____**

Please Complete the following:

Do you use hearing aids?	YES NO
Do you struggle to hear/understand conversations?	YES NO
Do you use a cane, walker, or wheelchair?	YES NO
Have you fallen within the past 12 months? If yes, how many times?	YES NO _____
Do you have a diagnosis of diabetes?	YES NO

Can you perform the following activities with or without assistance?

Getting in/out of bed/chair	WITH WITHOUT
Eating	WITH WITHOUT
Dressing yourself	WITH WITHOUT
Walking	WITH WITHOUT
Toileting	WITH WITHOUT
Housework	WITH WITHOUT
Shopping	WITH WITHOUT
Using the telephone	WITH WITHOUT

Have you had a colonoscopy? YES / NO **Year: _____** **Doctor: _____**

Have you had an annual mammogram? YES / NO **Year: _____**

Smoker: YES / NO **If yes, how many a day? _____**

Do you take cholesterol medication? YES / NO

Do you have high blood pressure? YES / NO

Have you had a surgery this year? YES / NO **If so, surgery and date: _____**

Patient Signature: _____ **Date: _____**

FOR OFFICE USE ONLY

Medication Reconciled: _____ Tobacco Hx Verified: _____

Surgical Hx Verified: _____ Family Hx Verified: _____

Physician Care Team Verified: _____ Entered in GW: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks,* 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 figety 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	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. 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 _____

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