WESTSIDE MEDICAL

HEALTH ASSESMENT

Today's Date: __

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Phone Number: _____ E-Mail: _____

☐Check here if you have someone who helps with your care.
*Please see the Front Desk to authorize the release of your protected health information

Caregiver Name: _____ Phone Number: _____ (If Applicable)

If you have someone who is highly involved in your healthcare it may be helpful to bring them to your appointment.

How do you prefer we communicate with you about important things?

☐ Talking on the phone
☐ Using e-mail/Patient Portal
☐ Using regular post office mail
☐ Communicate with caregiver

Please remember to bring all medications, supplements and Vitamins you are currently taking to this appointment

SELF ASSESMENT

1. Compared to one year ago, do you feel your **physical** health is: ☐ the same ☐ better ☐ worse
2. Compared to one year ago, do you feel your **mental** health is: ☐ the same ☐ better ☐ worse
3. During the past 4 weeks, how would you rate your health in general:
   ☐ Excellent ☐ Good ☐ Poor
4. How confident are you that you can control and manage most of your health problems?
   ☐ Very confident ☐ Not very confident
5. How often do you have trouble taking medicines the way they are prescribed?
   ☐ Never/Seldom ☐ Always/most of the time
6. Are you eating 3 well balanced meals every day? ☐ Yes ☐ No ☐ Sometimes

MOOD & STRESS

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

1. Little interest or pleasure in doing things?
   ☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly Every Day
2. Feeling down, depressed, or hopeless
   ☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly Every Day
3. How often is stress a problem for you?
   ☐ Never/Rarely ☐ Often
4. How often do you get the social and emotional support you need?
   ☐ Always/Usually ☐ Never/Rarely

ADVANCE DIRECTIVE

Do you have a Living Will? ☐ Yes ☐ No

If yes, please bring a copy to your next visit.

Do you need information regarding a Health Care Advance Directive: ☐ Yes ☐ No

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SOCIAL HISTORY

1. Please Describe your current living situation:
   - ☐ Live Alone
   - ☐ Live with One or More Adults
   - ☐ Live with One or More Children/Dependents
   - ☐ Live in an Assisted Living Facility
   - ☐ Live in a Skilled Nursing Facility
2. Do you exercise for about 20 minutes 3 or more days a week?
   - ☐ Yes, most of the time ☐ Yes, some of the time
   - ☐ No, I usually don't exercise this much

   List Type of Exercise: _____
3. How often do you drink alcohol?
   - ☐ Never ☐ Daily ☐ Occasionally
4. Have you ever used tobacco?
   - ☐ Yes ☐ No If yes: Year started using_____

If yes, indicate the type of tobacco used: _____

Are you still using tobacco? ☐ Yes ☐ No

Are you interested in help quitting? ☐ Yes ☐ No

SAFETY

1. Have you fallen within the past 3 months?
   - ☐ Yes ☐ No
2. Are you afraid of falling?
   - ☐ Yes ☐ No
3. Do you use handrails in the bathtub or shower?
   - ☐ Yes ☐ No
4. Do you need assistance with any of the following?
   - ☐ Getting dressed ☐ Showering or bathing
   - ☐ Using the toilet ☐ Laundry ☐ Shopping
   - ☐ Meal Preparation ☐ Eating/Feeding
   - ☐ Managing finances ☐ Managing medications
   - ☐ Transportation ☐ Other: _____
5. Do you have trouble hearing the television or radio when others do not? ☐ Yes ☐ No
6. Do you have to strain or struggle to hear/understand conversations? ☐ Yes ☐ No
7. Do you have any problems with your vision?
   - ☐ No Vision Problems ☐ Partial Vision Loss
   - ☐ Legally Blind ☐ Use Assistive Devices: _____
8. Do you always fasten your seatbelt when in a car?
   - ☐ Yes ☐ No
9. Would you like to receive more information about Home Safety?
   - ☐ Yes ☐ No

Medical History: Please provide details of all medical conditions, past and current. *Include a reason for all medications you take

Disease	Date of Diagnosis	Comments

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Surgical History: Please provide dates of previous surgeries			
Surgery	Date	Surgery	Date

Allergies: Please provide list of drug allergies			
Drug	Reaction	Drug	Reaction

FAMILY HISTORY: Please provide information for any health problems experienced by your family		
Family Member	Problem	Living or Deceased
Mother		
Father		
Siblings		
Other: _____		
Other: _____		

Other Physicians and Providers of Care: Please include Home Healthcare or Durable Medical Equipment Providers			
Name & Specialty/Provider Type	Type of Care	Name & Specialty/Provider Type	Type of Care

Have any of these providers recommended any changes to your treatment plan? Please specify:

☐ New Medications ☐ Testing ☐ Lab Work ☐ Other: _____

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Preventive Screenings and Services

Have you had any of the following preventive screenings or services performed? If so, please document the relevant information to the best of your knowledge.

Screening or Service	Who needs this?	When was this performed?	Where was this performed?
Bone Mass Measurement (DEXA scan)	People at risk for Osteoporosis		
Cardiovascular Screening Blood Tests	All adults		
Colorectal Cancer Screening	All adults 50 or older		
Diabetes Screening	All adults at risk		
Diabetes Self-Management Training (DSMT)	All adults at risk with known diabetes		
Glaucoma Screening	Adults at high risk for glaucoma		
Hepatitis B Vaccination	Adults at medium or high risk for Hepatitis B		
Hepatitis C Virus (HCV) Screening	Adults at high risk for Hepatitis C		
HIV Screening	All adults at risk for HIV infection		
Influenza Vaccination	All adults		
Medical Nutrition Therapy for Diabetes or Renal Disease	All adults at risk with known diabetes or renal disease		
Pneumococcal Vaccination	All adults		
Smoking Cessation Counseling	All adults who use tobacco		
Subsequent Annual Wellness Visit	All adults 65 or older		
Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)	Men ages 65-75, if at risk		
FEMALE PATIENTS			
Pap/Pelvic Exam	All women		
Screening Mammogram	Women over 40		
MALE PATIENTS			
Prostate Cancer Screening	Men over 50		