NAME_____ DATE_____

Annual Health Assessment

(Please Circle or Fill In Your Answer)

GENERAL HEALTH

1. In general, how would you describe your health?

   Excellent Very Good

   Fair Poor

2. Has this changed in the past 12 months?

   No Yes

   If yes circle: better worse

ACTIVITIES OF DAILY LIVING

3. Do you live?

   Alone

   With a spouse

   With a family member

   In a supervised care setting

4. How would you describe your diet:

   Balance Diabetic

   Healthy Low calorie

   Unhealthy

5. The past 7 days, did you need help from others with activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

   No Yes

6. When was your last eye exam?

   _____

PHYSICAL ACTVITY

7. Do you exercise?

   No (Skip to question #11)

   Yes (answer questions 8-11)

8. In the past 7 days, how many days did you exercise?

   _____

9. How long did you exercise in minutes on these days?

   _____

10. How intense was your typical exercise?

    Light – I could talk and sing while exercising

    Moderate – I could talk but not sing

    Heavy – I could not talk

    Very Heavy – competitive sports like soccer, tennis

11. Do you have physical limitation that prevents you from exercising? _____

FALL RISK ASSESSMENT

12. Have you had a fall in the last 12 months?

    No (skip to question 18)

    Yes (answer questions 13-17)

13. Number of falls in the last 12 months?

    One Two Three or More

14. Has an injury resulted from your fall(s)?

    No Yes

15. Do you have difficulty with balance?

    No Yes

16. Do you have trouble stepping up onto a curve?

    No Yes

17. Do you use any equipment or assistive devices for walking?

    No Yes

    What type? _____

18. Do you have to get up quickly to go to the restroom?

    No Yes

19. Have you lost feeling in your feet?

No Yes

20. Do you take medicine that makes you feel light-headed or tired?

No Yes

PAIN

21. In the past 7 days have you had any pain?

No (skip to question 25)
Yes (answer question 22-24)

Where is your pain?_____

22. On a scale of 1 to 10 with 1 being limited and 10 bearable how would you rate your pain?

1 2 3 4 5 6 7 8 9 10

23. What medication do you take for your pain?

None Narcotics

OTC Medication Other_____

24. Is your current medication controlling your pain?

No Yes

TOBACCO USE

25. Do you use tobacco?

No (skip to question 27)

Yes (answer question 26)

26. Are you interested in quitting tobacco use?

No Yes

Alcohol Use Screening

27. Do you drink alcohol?

No (skip to question 33)

Yes (answer 29-32)

NAME_____

28. How often did you have a drink in the last year?

Never	0pts
Monthly of less	1pts
Weekly	2pts
2-3 times a week	3pts
4 or > times a week	4pts

29. How many drinks did you have on a typical day when you had a drink?

1 or 2 drinks	0pts
3 or 4 drinks	1pts
5 or 6 drinks	2pts
7 or 9 drinks	3pts
10 or more	4pts

30. How often did you have 6 or more drinks (4 or more for women) on one occasion in the last year?

Never	0pts
Monthly	1pts
Twice a Month	2pts
Weekly	3pts
Daily	4pts

31. Have you or someone else been injured because of Your drinking?

No Yes

32. Has a relative, friend, or healthcare provider been concerned about your drinking and encouraged you to stop?

No Yes

Advanced Directives/Living Will

A Living Will states to your family, your wishes for you medical care if you are in a bad accident or have a terminal illness and can't make your wishes known. A Power of Attorney (POA) appoints someone in your family to make decisions for you in case you are unable to do so.

33. Do you know what an Advanced Directive/Living Will is?

No Yes

34. Have you completed an Advance Directive/Living Will?

No Yes