Last Name	First Name	MI	Date of Birth

Leila Rhodes M.D., Inc.

Visit Date _____

ANNUAL HEALTH ASSESSMENT

Important Notice: The information gathered on this questionnaire will remain confidential.

Your insurance has asked us to provide the following information. Please answer the questions to the best of your ability. This will allow you doctor to screen topics to review during your visit.

Activities of Daily Living: Do you need assistance with the following?

1.	Bathing?	○ Yes	○ No	5.	Controlling urinary and fecal discharge?	○ Yes	○ No
2.	Dressing and Undressing?	○ Yes	○ No	6.	Using the toilet?	○ Yes	○ No
3.	Eating?	○ Yes	○ No	7.	Walking?	○ Yes	○ No
4.	Transferring from bed to chair and back?	○ Yes	○ No				

Fall Risk Screening:

1.	Have you had a fall in the last 3 months?	○ Yes	○ No
	If yes, how many times?		
	If yes, were you injured?	○ Yes	○ No
2.	Are you on 4 (four) or more medications?	○ Yes	○ No
3.	Do you have incontinence?	○ Yes	○ No
4.	Do you have visual impairments?	○ Yes	○ No
	If yes, do you wear glasses or contact lenses?	☐ glasses	☐ contacts
6.	Do you have loss of function in a limb, impaired mobility?	○ Yes	○ No
7.	Do you have stairs or a bathtub?	○ Yes	○ No
	If yes, select which one(s):	☐ stairs	☐ bathtub
9.	Do you have a known diagnosis of dementia?	○ Yes	○ No
10.	Do you use a walker, cane, wheelchair or assist device?	○ Yes	○ No
	If yes, select which one(s):	☐ walker ☐ cane ☐ wheelchair ☐ assist device	

Safety Precautions: Do you have any concerns about the following?

1.	Wearing a helmet when riding a bike	○ Yes	○ No	4.	Your hearing	○ Yes	○ No
2.	Exercising regularly	○ Yes	○ No	5.	Climbing stairs	○ Yes	○ No
3.	Your eye sight	○ Yes	○ No				

Social History:

1.	Marital Status:			
2.	Occupation:			
	If retired or unemployed, what was your prior occupation?			
3.	Tobacco Use:	○ Yes	○ Yes, but I quit	○ No, never
	If yes, how many packs a day?		If you quit, when? (approx. date)	
4.	Alcoholic Beverage Use:	○ Yes	○ Yes, but I quit	○ No, never
	If yes, how many drinks per week?		If you quit, when? (approx. date)	

Pain Screening:

1.	Do you have pain? (If no, skip this section)	○ Yes	○ No
2.	Is it acute (new) or chronic (lingering) pain?	○ acute	○ chronic
3.	Where is your pain?		
4.	On a scale of 0 to 10, 0 being no pain and 10 being the worst pain imaginable, what is your pain level?		
5.	What treatment or medication do you use for pain?		
6.	In the past, how much relief has pain medication provided? Select one.	○ 0% ○ 25% ○ 50% ○ 75% ○ 100%	
7.	Select the following if affected by pain:		

☐ Bathing/Dressing ☐ Mood ☐ Walking Ability ☐ Employment ☐ Housework ☐ Sleep
☐ Relationship with others ☐ Enjoyment of life ☐ Transportation ☐ Toileting ☐ Food Preparation

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Family and Home Environment:

1.	Living with:	☐ Spouse	☐ Child	☐ Caregiver	☐ Alone	☐ Skilled Facility	Other:								
2.	Transportation:	☐ Self	☐ Depends on spouse	☐ Depends on children	☐ Depends on caregiver	Other:									
3.	Do you have an Advanced Directive?	○ Yes	○ No	If yes, does your doctor have a copy?	○ Yes	○ No									
4.	Do you wear dentures?	○ Yes	○ No	If yes, are they removable?	○ Yes	○ No									

Depression Screening: Please select the option that applies to each feeling.

	Over the last 2 weeks, how often have you been bothered by any of the following problems?	0-Not at all	1-Several days	2-More than half the days	3-Nearly every day
1.	Little interest or pleasure in doing things	○	○	○	○
2.	Feeling down, depressed, or hopeless	○	○	○	○
3.	Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4.	Feeling tired or having little energy	○	○	○	○
5.	Poor appetite or overeating	○	○	○	○
6.	Feeling bad about yourself or have let yourself or family down	○	○	○	○
7.	Trouble concentrating on things, such as reading or watching TV	○	○	○	○
8.	Moving or speaking so slowly that other people could have noticed. Or the opposite, feeling fidgety more than usual	○	○	○	○
9.	Thoughts you would be better off dead, or hurting yourself in some way	○	○	○	○
		[For Office Use: Overall Score:			0]
10.	If you checked off any problems, how difficult have these problems made it for you to do our work, take care of things at home, or get along with other people?	○ Not difficult at all	○ Somewhat difficult	○ Very difficult	○ Extremely difficult

Health Maintenance / Screening Schedule: Enter date of your last screening.

1.	Bone Density	
2.	Cholesterol Test	
3.	Colorectal Cancer Screening (colonoscopy or stool cards)	
4.	Diabetic Screening (eye exam or glaucoma test)	
5.	Flu Shot	
6.	Mammogram or Prostate Exam	
7.	Pneumonia Shot / Vaccine	
8.	Shingles Shot / Vaccine	
9.	Eye Exam (with who?)	

List all Medications and Supplements:

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