F-65↑

FORT BEND Premier CARE

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Family Medicine

NAME:_____ D.O.B.:_____

EXAM DATE:_____ TIME:_____

Dear Patient: In preparation for your "Welcome to Medicare" preventative exam, "Annual Medicare Wellness" exam, or the Annual Physical that your insurance company requires – we ask that you do the following:

1) Please complete the attached forms and bring with you to your appointment. It is important for your provider to have these forms to review during your visit. For HIPAA reasons, your **name** and **date of visit** (date of birth optional) need to be on **EACH** page.
2) Bring a list of ALL your current medications, including vitamins and supplements - dosage and frequency of taking.
3) Answer the following questions:

- When was your last colonoscopy and by whom? (Bring report if you have it)

- When was your last eye exam and by whom? (Bring report if you have it)

- Do you have ADVANCE DIRECTIVES i.e. Living Will, Medical POA, etc.?(Bring copies)
- For Women – when was your last PAP exam?

- When was your last Mammogram and Bone Density? (Bring a copy of reports)

- Men: When was your last Prostate exam? PSA? (Bring copy of any reports/results)

- Are you up-to-date with your immunizations? Which ones: Shingles, Flu, COVID, tetanus, pneumonia. When did you get the immunizations and where if not here. (Exact dates not necessary – but about when? Pharmacy – or other MD office if not here?

- Do you see specialists? Who and for what?

1505 Liberty St., Richmond, TX 77469 ph: 281-342-9500; fax 281-342-6667

Name: D.O.B. Date:

Epworth Sleepiness Scale[11]

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

	Would never nod off 0	Slight chance of nodding off 1	Moderate chance of nodding off 2	High chance of nodding off 3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				

Add up your points to get your total score. A score of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices, or seek medical attention to determine why you are sleepy.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ D.O.B. _____ 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 _____

A2663B 10-04-2005

D.O.B.

Patient Name: _____ **Date:** _____

Patient ID # _____

Katz Index of Independence in Activities of Daily Living

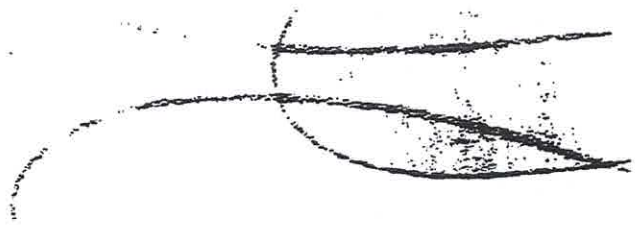
Activities Points (1 or 0)	Independence (1 Point) NO supervision, direction or personal assistance.	Dependence (0 Points) WITH supervision, direction, personal assistance or total care.
BATHING Points: _____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: _____	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.
TOTAL POINTS: _____	**SCORING:** 6 = High (*patient independent*) 0 = Low (*patient very dependent*	

Source:
try this: Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

MaineHealth

D.O.B. _____

Safe Questionaire



Patient's Name: _____

Physician's Name: _____ Date: _____

Do you feel safe in your relationship?

Have you ever been in a relationship where you were threatened, hurt or afraid?

Are your friends or family aware that you have been hurt? Could you tell them, and they would be able to give you support?

Do you have a safe place to go and the resources you need in an emergency?

References: Ashur, ML. Asking about domestic violence: SAFE questions. *JAMA* 1993; 269:2367.

NAME:

D.O.B.:

Today's Date:

The CAGE and CAGE-AID Questions

The original CAGE questions appear in plain type. The CAGE questions Adapted to Include Drugs (CAGE-AID) are the original CAGE questions modified by the *italicized text.*

The CAGE or CAGE-AID should be preceded by these two questions:

1. Do you drink alcohol?
2. Have you ever experimented with drugs?

If the patient has experimented with drugs, ask the CAGE-AID questions. If the patient only drinks alcohol, ask the CAGE questions.

CAGE and CAGE-AID Questions

1. In the last three months, have you felt you should cut down or stop drinking or *using drugs?*
   Yes No
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or *using drugs?*
   Yes No
3. In the last three months, have you felt guilty or bad about how much you drink *or use drugs*?
   Yes No
4. In the last three months, have you been waking up wanting to have an alcoholic drink or *use drugs*?
   Yes No

Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.

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A7012-DA-4W

Self-Test for Anxiety

Name: D.O.B Date:

You can complete the highlighted fields on this form online and then print the form for easy reference. Only text that is visible on the form is printed; scrolled text will not print. Any text you enter into these fields will be cleared when you close the form; you cannot save it.

This questionnaire— called the GAD-7 screening tool— can help you find out if you might have an anxiety disorder that needs treatment. It calculates how many common symptoms you have and— based on your answers— suggests where you might be on a scale, from mild to severe anxiety.

GAD-7 stands for "generalized anxiety disorder" and the 7 questions in the tool. Choose one answer for each of the 7 questions below:

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3
Add up your results for each column				
Total score (add column totals together)				

What your total score means

Your total score is a guide to how severe your anxiety disorder may be:

- 0 to 4 = mild anxiety
- 5 to 9 = moderate anxiety
- 10 to 14 = moderately severe anxiety
- 15 to 21 = severe anxiety

If your score is 10 or higher, or if you feel that anxiety is affecting your daily life, call your doctor.

The GAD-7 was developed by Drs. Robert L. Spitzer, Janet B. W. Williams, Kurt Kroenke, and colleagues, with an education grant from Pfizer, Inc.

Name: D.O.B. Date:

The Questionnaire for female Urinary Incontinence Diagnosis (QUID)

Do you leak urine (even small drops), wet yourself, or wet your pads or undergarments...	None of the time	Rarely	Once in a while	Often	Most of the time	All of the time
1. when you **cough** or **sneeze**?	☐	☐	☐	☐	☐	☐
2. when you **bend down** or **lift something up**?	☐	☐	☐	☐	☐	☐
3. when you **walk quickly, jog** or **exercise**?	☐	☐	☐	☐	☐	☐
4. while you are **undressing** in order to use the **toilet**?	☐	☐	☐	☐	☐	☐
5. Do you get such a **strong and uncomfortable need** to urinate that you leak urine (even small drops) or wet yourself before reaching the toilet?	☐	☐	☐	☐	☐	☐
6. Do you have to **rush to the bathroom** because you get a **sudden, strong need** to urinate?	☐	☐	☐	☐	☐	☐

Scoring:

Each item scores 0 (None of the time), 1 (Rarely), 2 (Once in a while), 3 (Often), 4 (Most of the time) or 5 (All of the time). Responses to items 1, 2 and 3 are summed for the Stress score; and responses to items 4, 5, and 6 are summed for the Urge score.