MedFlorida
Medical Centers

Patient Name: _____ DOB: _____ DATE: ____/____/_____

1. Date of last physical: (____/_____/_____)
2. Cognitive (Memory) changes: __ yes __ no
3. Functional Assessment: (*Please underline anything that you can NOT do.)* Are you able to perform Activities of Daily Living without assistance able to perform and IADLs without assistance? Able to shop for groceries, Drive or use public transportation, Use the telephone, Prepare meals, Perform housework, Do home repairs, Laundry, Take medications, Handle finances.
4. Balance problems: __ yes __ no
5. Vision Disturbances: __ yes __ no
6. Hearing Problems: __ yes __ no
7. Advanced Directives (Living Will): Recommended. Do you have one? __ yes __ no
8. Pain Assessment: 1-10 (no pain – unbearable pain) ____/10
   If positive where is it located? _____
9. Urinary Incontinence: __ yes __ no
10. Colonoscopy __ NO __YES Date: ___/ _____ or Stool Test __ NO __YES Date: ___/ _____
11. EKG Date of last exam: ___/ _____
12. Eye Exam Date of last exam: ___/ _____
13. Dental Visit Date of last exam: ___/ _____
14. Risk of Falls in Older Adults :
    - History of Falls __ yes __ no If positive how many times & when?
      _____
    - Mobility: Need of Assistive Equipment (cane, walker, furniture, etc.) __ yes __ no
    - Debilitation (weight loss or weakness) __ yes __ no
    - Fully ambulatory __ yes __ no
    - Unsteady Gait / Balance __ yes __ no
15. Immunizations:
    - Pneumococcal Vaccine __ NO __YES Date: ___/ _____
    - Influenza Vaccine __ NO __YES Date: ___/ _____
16. FEMALE Only :
    - Mammogram __ NO __YES Date of last exam: ___/ _____
    - Pap Smear __ NO __YES Date of last exam: ___/ _____
    - Breast Self Exam __ yes __ no
    - DEXA Date of last exam: ___/ _____
17. MALE Only :
    - PSA (Prostate Specific Antigen) Last PSA was done on (___/ ___/ _____)
    - Testicular Self Exam __ yes __ no
    - Rectal Exam Date of last exam: ___/ _____