Today's Date: _____

Patient checklist

What's on your mind today? Please mark any of the following items you would like to talk about with your physician.

NAME _____

HEALTH AND WELL-BEING

Please circle the items below you would like to discuss:

- ☐ Medications
- ☐ Screenings and tests
- ☐ Diabetes
- ☐ Vaccinations
- ☐ Other

HEALTH DISCUSSIONS

Please tell your physician if you are having problems with any of these:

- ☐ Urine leakage / bladder control
- ☐ Balance problems or falling

HEALTHY LIVING

To help keep myself healthy, I would like to work on:

- ☐ Exercise
- ☐ Diet and healthy eating
- ☐ Weight loss
- ☐ Coping with stress
- ☐ Reducing unhealthy habits
- ☐ Taking medicine correctly

GENERAL HEALTH SCREENING

During the past four weeks, how would you rate your health in general?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

How often during the past four weeks have you been bothered by any of the following problems?

- ☐ Falling or dizzy when standing up.
- ☐ Sexual Problems
- ☐ Trouble eating well.
- ☐ Teeth or Denture Problems
- ☐ Tiredness or Fatigue.

STRESS SCREENING

Do you feel stress - tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time - these days?

- ☐ Not at all
- ☐ Only a little
- ☐ To some extent
- ☐ Rather much
- ☐ Very much
- ☐ Patient declined to specify

PHYSICAL EXERCISE

- How many days of the week do you engage in moderate to strenuous exercise, (ex: a brisk walk)? ____
- On those days, how many minutes, on average, do you exercise? ____

ALCOHOL USE

1. How often do you have a drink containing alcohol?
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2-4 times a month
   - ☐ 2-3 times a week
   - ☐ 4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day?
   - ☐ 1 or 2
   - ☐ 3 or 4
   - ☐ 5 or 6
   - ☐ 7 to 9
   - ☐ 10 or more
3. How often do you have 6 or more drinks on 1 occasion?
   - ☐ Never
   - ☐ Less than monthly
   - ☐ Monthly or less
   - ☐ Weekly

DEPRESSION QUESTIONNAIRE:

Over the last 2 weeks, how often have you been bothered by 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

PAIN SCREENING

During the past four weeks, how much bodily pain have you generally had?

- ☐ No pain.
- ☐ Very mild pain.
- ☐ Mild pain.
- ☐ Moderate pain.
- ☐ Severe pain.

On a scale of 1-10 (10 being the most severe) what would you rate your pain?☐

DEVELOPMENTAL HISTORY:

Have you fallen two or more times in the past year? ☐Yes ☐ No

Do you use a walking of mobility device? If so, what type: _____