CoreMed Plus

Annual Physical Screen

Patient Name:_____DOB:_____Date: _____

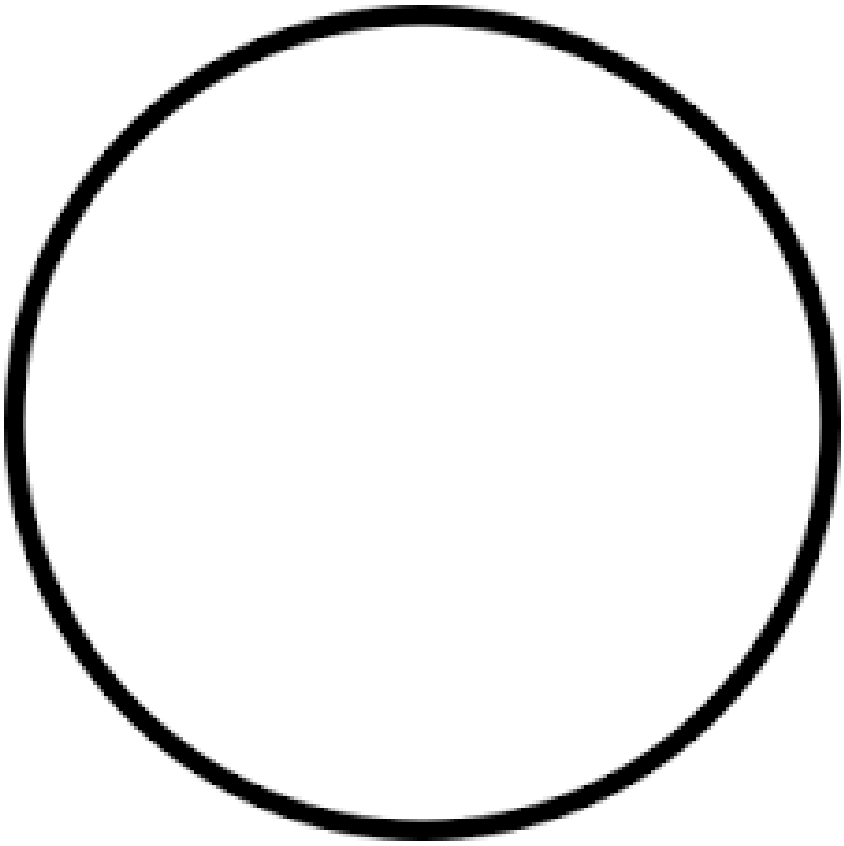
Email: _____SS:_____Phone:_____

Fall Risk Screening:

Have you fallen in the past year?	***Yes***	***No***
Do you feel unsteady when standing or walking?	***Yes***	***No***
Are your worried about falling?	***Yes***	***No***

Cognitive Test- Clock Drawing

Please draw numbers in the circle to make the circle look like the face of a clock. Draw the hands of the clock to read "10 minutes after 11 o'clock"



Activity of Daily Living (ADLs)

Do you need help from others for your personal care; such as eating, dressing, toileting or getting around the house?	***Yes***	***No***
Do you experience incontinence?	***Yes***	***No***
Do you need help with using the telephone?	***Yes***	***No***
Do you need help with shopping?	***Yes***	***No***
Do you need help with food preparation?	***Yes***	***No***
Do you need help with housekeeping?	***Yes***	***No***
Do you need help with laundry?	***Yes***	***No***
Do you need help handling finances?	***Yes***	***No***
Do you drive?	***Yes***	***No***
Do you manage your own medication?	***Yes***	***No***

Health and Safety

Do you view your health as?	***Excellent***	***Good***	***Fair***	***Poor***
Do you view your life as?	***Excellent***	***Good***	***Fair***	***Poor***
Do you think your sleep pattern is?	***Sleeping well***	***Up all night***	***Restless***	***Sleeping more***
Have you seen a dentist in the last year?			***Yes***	***No***
Do you exercise for about 20 minutes or more, three days a week?	***Yes, sometimes***	***Yes, most of the time***	***Yes, always***	***No***
Do you eat a balanced diet including daily serving of fruits, vegetables, and whole grains?	***Yes, sometimes***	***Yes, most of the time***	***Yes, always***	***No***
Do you live alone?			***Yes***	***No***
Does your home have throw rugs, poor lighting, or a slippery bathtub/shower?			***Yes***	***No***
Does your home have a functioning smoke detection?			***Yes***	***No***
Do you use any assistive devices?			***Yes***	***No***
Do you always fasten your seatbelt?			***Yes***	***No***

Depression Screening

Over the LAST 2 Weeks:	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
How often have you been bothered by little interest or pleasure in doing things?	**0**	**1**	**2**	**3**
How often have you been bothered by feeling down, depressed or hopeless?	**0**	**1**	**2**	**3**
How often have you been bothered by trouble falling or staying asleep, or sleeping too much?	**0**	**1**	**2**	**3**
How often have you been bothered by feeling tired or having little energy?	**0**	**1**	**2**	**3**
How often have you been bothered by poor appetite or overeating?	**0**	**1**	**2**	**3**
How often have you been bothered by feeling bad about yourself- or that you are a failure or have let yourself or your family down?	**0**	**1**	**2**	**3**
How often have you been bothered by trouble concentrating on things, such as reading the newspaper or watching television?	**0**	**1**	**2**	**3**
How often have you been bothered by moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual?	**0**	**1**	**2**	**3**
How often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?	**0**	**1**	**2**	**3**

If you checked off any problems, how diffcult 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 difficul**

Name: _____3_____

DOB: _____Date:_____

Alcohol Screening

How often do you have a drink containing alcohol?

0= Never 1= Monthly or less 2= 2-4 times a month

3= 2-3 times a week 4= 4 or more times a week

How many standard drinks containing alcohol do you have on a typical day?

0= 1 or 2 drinks 1= 3 or 4 drinks 2= 5 or 6 drinks

3= 7 to 9 drinks 4= 10 or more

How often do you have six or more drinks on one occasion?

0= Never 1= Less than monthly 2= Monthly 3= Weekly 4= Daily or almost daily

Social Influencers of Health

Within the past 12 months we worried whether our food would run out before we got money to buy more

Never True Sometimes true Often True

Within the past 12 months the food we bought just didn't last and we didn't have money to get more

Never True Sometimes true Often True

How hard is it for you to pay for the very basics like food, housing, medical care and air conditioning/heating?

Very hard Hard Somewhat hard Not very hard

Are you worried that in the next 2 months you may not have stable housing? ***Yes No***

Do you have access to a variety of food including fruits and vegetables? ***Yes No***

Within the last 3 months, how many times did you visit the emergency department for your medical care? _____

Has the lack of transportation kept you from meetings, work, or from getting things needed for daily living?

Yes No

Has the lack of transportation kept you from medical appointments or from getting medications?

Yes No

How often do you feel lonely or isolated from those around you?

Never Rarely Sometimes Often Always

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never Rarely Sometimes Often Always

Do you think completing more education or training, like finishing a GED, going to college, or learning a trade, would be helpful for you?

Yes No

Do you need help finding or paying for care for your loved ones. For example, child care or elderly care for an older adult?

Yes No

Are you afraid that you might be hurt by violence in your apartment of home?

Yes No

If you answered **YES** to any questions above, would you like to receive assistance with any of these needs?

Yes No

Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight?

Yes No

Diabetic Patients:

Do you have Diabetes: Yes_____, No_____

IF yes, Are you on Insulin: Yes_____, No_____

Last Eye Exam: _____

Last Foot Exam: _____

Last HGA1C: _____ Value: _____

Statin Therapy:

Are you on Statin: Yes___, Name of your medication:_____

No____, Did you have any reaction to Statin in the past:_____

Allergies:

Have you ever had an allergic reaction to medication, food, or any other substance? If yes, please describe:

Substance	Reaction	Year (approx.)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications:

Preferred Pharmacy: _____

Please list below any changes to your medication regimen since your last visit

Name	**Amount**	**How Often**
_____		
_____		
_____		
_____		
_____		
_____		

Health Screening:

Mammogram: Yes____, Last One:_____, No____

Colonoscopy: Yes____, Last One:_____, No____

ColoGuard: Yes____, Last One:_____, No____

Immunizations History:

Flu: Yes____, Date:_____, No____

Pneumonia: Yes____, Date:_____, No____

Shingles: Yes____, Date:_____, No

Tobacco use:

Current Everyday Smoker Current Some Day Smoker Never Former Smoker

Passive Light Smoker

Smokeless Tobacco Use:

Current User Never Used Former Use

Advance Care Planning:

Do you have an advance directive? Example: Living Will or Durable Power of Attorney for Health Care (DPoA-HC) ***Yes*** ***No***

If yes, when was it last updated? _____

If no, would you like more information about advance care planning? ***Yes*** ***No***