MIDWEST Health Partners, P.C.

**Medical Questionnaire**

PATIENT INFO

For the purpose of: _____ Medicare Welcome Visit _____ Medicare Annual Wellness Visit (plus Clock Test)

Today's date: _____ Patient Name: _____

DOB: _____

FALL RISK SCREENING

1 Are you afraid of falling? _____NO _____YES

2 Have you fallen in the past year? _____NO _____YES

3 If yes, check the circumstances surrounding the fall:

____ Tripped over something
____ Lightheadedness or palpitations prior to
____ Loss of consciousness
____ Injured
____ Needed to see a doctor
____ Able to get up on my own

ADMISSION SCREENINGS

1 Have you experienced unintended weight loss in the last 2 months? _____NO _____YES

2 Have you ever had the pneumococcal vaccination? _____NO _____YES

3 Have you had the influenza vaccine this season? _____NO _____YES

4 Have you had any recent decline in your mobility? _____NO _____YES

5 Have you had any recent changes in your ability to perform daily living activities _____NO _____YES

6 Do you have a history of falls? _____NO _____YES

7 Are you deaf or do you have difficulty hearing? _____NO _____YES

8 Are you blind or have difficulty seeing (even when wearing glasses)? _____NO _____YES

9 Do you have difficulty concentrating or remembering? _____NO _____YES

10 Do you have diffculty walking or climbing stairs? _____NO _____YES

11 Do you have difficulty dressing or bathing? _____NO _____YES

12 Do you have difficulty running errands alone? _____NO _____YES

13 Do you use any of the following assistive devices?

_____ Glasses _____ Cane / Walker _____Wheel Chair _____ Other

## HEARING IMPAIRMENT SCREENING

1 Do you wear Hearing Aids? _____NO _____YES

2 Does a hearing problem cause you to feel embarrassed when meeting new people? _____NO _____YES

3 Does a hearing problem cause you to feel frustrated when talking to members of your family? _____NO _____YES

4 Do you have difficulty hearing when someone speaks in a whisper? _____NO _____YES

5 Do you feel handicapped by a hearing problem? _____NO _____YES

6 Does a hearing problem cause you difficult when visiting friends, relatives or neighbors? _____NO _____YES

7 Does a hearing problem cause you to attend religious services less often than you would like? _____NO _____YES

8 Does a hearing problem cause you to have arguments with family members? _____NO _____YES

9 Does a hearing problem cause you difficulty when listening to TV or radio? _____NO _____YES

10 Do you feel that any difficulty with your hearing limits or hampers your personal or social life? _____NO _____YES

11 Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? _____NO _____YES

## HOME SAFETY

1 What is your current type of residence:

_____House _____Condo/apartment _____Assisted Living
_____ Group Home _____ Nursing Home

2 Are there stairs? _____NO _____YES

3 Who lives in the home with you?

_____Spouse ____ Family ____ Caregiver ____ Lives alone

4 Do you have any of the listed assistive devices used in your home? _____ Other

_____ Comfort-level toilets _____Stair lifts _____Chair lift
_____Hospital bed _____ Grip bars

5 Do you currently drive? _____NO _____YES

6 Have there been any recent episodes or accidents while becoming lost/disoriented? _____NO _____YES

7 What do you use to heat/cool your home?

_____ Oil heat _____ Gas heat _____ Electric heat pump / AC _____ Space heaters
_____ Fans _____ Open windows, screens _____ In-windows a/c unit
_____ Central Air Conditioning

## HOME SAFETY

8 Are these serviced on a regular basis? _____NO _____YES

9 Do you have either the the following working in your home?

Smoke Alarms _____NO _____YES

Carbon monoxide detectors _____NO _____YES

10 What home appliances are used to cook in your home?

_____ Gas oven/stove _____ Microwave _____ Crockpot _____ Toaster Oven
_____ Electric oven/stove _____ Outdoor grill

## HOME CARE

1 What type of support do you rely on for help?

_____ Spouse/partner _____ Case manager / social worker _____ Organized support groups
_____ Parent _____ Church members _____ Shelter
_____ Children _____ Friends / neighbors _____ Therapist
_____ Family members _____ Homecare staff _____ NONE

2 What type of assistance do you need at home?

_____ Supervised settings _____ Equipment _____ Respiratory care
_____ Home health _____ Daily living activities ____ In-home caregiver
_____ Rehabilitation _____ Medications _____ Education support

## CURRENT MEDICAL

1 Please list any current medical problems or conditions:

_____ _____
_____ _____
_____ _____
_____ _____

2 Physicians / Practitioners you currently see:

NAME SPECIALTY

_____ _____
_____ _____
_____ _____
_____ _____

3 Please list any allergies you may have:

_____ _____
_____ _____

4 Do you have any history of substance abuse: _____NO _____YES

## MEDICATIONS

1 How do you keep track of your daily medications?

_____No method _____ Medicines lined up _____Pre-placed pills in a pillbox

_____ Bubble packs of meds for each day/time

2 Who administers your medications? _____Self ____Spouse _____Family member
____ Caregiver

3 List any medication that you currently take, including over-the-counter:

| Med Name | Strength | How often | Prescribed by |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## HEALTH LITERACY

1 How often do you have someone help you read health or medical material? (Please circle)

Never Occasionally Sometimes Often Always

2 How often do you have problems learning about your medical condition because of difficulty understanding written information?

Never Occasionally Sometimes Often Always

3 How often do you have a problem understanding what is told to you about your health or medical condition?

Never Occasionally Sometimes Often Always

4 How confident are you filling out health or medical forms by yourself?

Extremely Quite a bit Somewhat A little bit Not at all

## EDUCATION

1 What learning and/or communication barriers do you have?

| | | |
|---|---|---|
| ____ No barriers | ____ Physical | ____ Visual |
| ____ Reading | ____ Emotional | ____ Financial |
| ____ Language | ____ Cognitive | ____ Other:_____ |

2 What is your preferred language for educational material? _____

3 Would you like an interpreter for education and learning? _____NO _____YES

4 Are you ready to learn about your health plan and plan of care? _____NO _____YES

5 Do you have any cultural or religious beliefs that might impact your education and learning?
_____NO _____YES

6 What is the best way for you to learn?

| | | |
|---|---|---|
| ____ Listening | ____ Demonstration | ____ Combination of these |
| ____ Reading | ____ Video / Pictures | ____ Other: _____ |

## ROUTINE TASKS

Please indicate if you do or do not need help performing these routine tasks

| | | | |
|---|---|---|---|
| 1. Feeding yourself | ____ NO | _____ YES | Who helps? _____ |
| 2. Getting from bed to chair | ____ NO | _____ YES | Who helps? _____ |
| 3. Getting to the toilet | ____ NO | _____ YES | Who helps? _____ |
| 4. Getting dressed | ____ NO | _____ YES | Who helps? _____ |
| 5. Bathing or showering | ____ NO | _____ YES | Who helps? _____ |
| 6. Walking across the room | ____ NO | _____ YES | Who helps? _____ |
| 7. Using the telephone | ____ NO | _____ YES | Who helps? _____ |
| 8. Taking your medicines | ____ NO | _____ YES | Who helps? _____ |
| 9. Preparing meals | ____ NO | _____ YES | Who helps? _____ |
| 10. Managing money | ____ NO | _____ YES | Who helps? _____ |
| 11. Moderately strenuous housework | ____ NO | _____ YES | Who helps? _____ |
| 12. Shopping for personal items | ____ NO | _____ YES | Who helps? _____ |
| 13. Shopping for groceries | ____ NO | _____ YES | Who helps? _____ |
| 14. Driving | ____ NO | _____ YES | Who helps? _____ |
| 15. Climbing a flight of stairs | ____ NO | _____ YES | Who helps? _____ |
| 16. Traveling across town | ____ NO | _____ YES | Who helps? _____ |

## HEALTH MAINTENANCE

Please record the last year you had the following exam or screening done:

| | Previsouly tested, when? | Scheduled for screenings |
|---|---|---|
| Bone Mass Measurements | _____ | _____ |
| Cardiovascular tests (Lipid Panel, EKG) | _____ | _____ |
| Collorectal Screening (hemocult, colonscopy) | _____ | _____ |
| Diabetes screening (glucose) | _____ | _____ |
| Diabetes Self-Management training | _____ | _____ |
| Medical Nutritional Therapy | _____ | _____ |
| Glaucoma Screening | _____ | _____ |
| Prostate Cancer screening (PSA) | _____ | _____ |
| Pap Smear | _____ | _____ |
| Pelvic Exam (with clinical breast exam) | _____ | _____ |
| Mammogram | _____ | _____ |
| Pneumonia vaccine shot | _____ | _____ |
| Flu vaccine shot | _____ | _____ |
| Hep B shot | _____ | _____ |
| Ultrasound screening for Abdominal Aortic Aneurysm | _____ | _____ |

Would you like information about where to obtain any of these services? _____YES

## HEALTHCARE DIRECTIVES

1 Do you have a living will (Advanced Directive)? _____NO _____YES

2 Do you have a Durable Power of Attorney? _____NO _____YES

Notes: _____

Patient / Authorized Signature: _____ Date: _____

Reviewed by: _____ Date: _____