Mental/Emotional Health

	No	Yes
50. Felt exhausted or fatigued most of the time?	☐	☐
51. Have you had trouble falling or staying asleep, or sleeping too much?	☐	☐
52. Have you felt tired or had too little energy?	☐	☐
53. Felt "blue", lonely, depressed, or hopeless?	☐	☐
54. Had little interest or pleasure in doing things?	☐	☐
55. Been more irritable than usual?	☐	☐
56. Had frequent crying spells or felt like crying?	☐	☐
57. Had difficulty trying to calm down or relax?	☐	☐
58. Been overly anxious or been worrying a lot?	☐	☐
59. Felt you or others would be better off if you were dead?	☐	☐
60. Desired or sought counseling?	☐	☐

61. What is today's date? _____
62. What is the current month? _____
63. What year is it? _____
64. What day of the week is it? _____
65. What season is it? _____
66. What is the name of the place you are in? _____
67. Who is the current President of the United States? _____
68. What city are we in? _____
69. What country are we in? _____
70. What state are we in? _____

Eating and Drinking

	No	Yes
71. How many servings of fruits and vegetables do you eat on most days? _____		
72. How many servings of fried foods do you eat on most days? _____		
73. How many 8 oz. glasses of fruit juice or sweetened Do you drink on most days? _____		
74. Has your appetite noticeably changed in the past month?	☐	☐
75. Have you gained/lost 10 or more pounds in the past 6 months?	☐	☐
76. Do you drink caffeinated coffee, tea or soda? If yes, how many cups per day? _____	☐	☐
77. Do you smoke, vape, or use tobacco now? If yes, how many times per day? _____	☐	☐
78. Have you smoked, vaped, or used tobacco in the past? If yes, when did you start? Year _____ If yes, when did you quit? Year _____ If yes, what type of tobacco did you use? _____	☐	☐
79. Do you drink more than 2 alcoholic beverages a day? If yes, how many drinks per day? _____	☐	☐
80. How many days per week do you have a drink? _____		
81. Have you ever felt you ought to cut down on your drinking?	☐	☐
82. Have you ever been annoyed by people criticizing your drinking?	☐	☐
83. Have you ever felt bad or guilty about your drinking?	☐	☐
84. Have you ever had a morning "eye opener" to steady your nerves?	☐	☐
85. Have you ever taken medication that was not prescribed to you?	☐	☐
86. Have you ever taken opioids (narcotics)?	☐	☐
87. Have you ever used recreational drugs?	☐	☐

Work and Play

88. What kind of exercise do you do? _____
    _____
    Frequency: _____
89. What are your hobbies or leisure activities?
    _____
90. In what kinds of groups, organizations or community activities do you participate? _____
    _____
    _____
91. List the countries you have visited in the past 5 years:
    _____
    _____

	No	Yes
92. Are you generally satisfied with your work?	☐	☐
93. Do you usually wear a safety belt when riding in a car?	☐	☐
94. Are there working smoke detectors in your house?	☐	☐
95. Are there any guns in your house?	☐	☐

Sexuality

	No	Yes
96. Are you sexually active?	☐	☐
97. Are you generally satisfied with sex?	☐	☐
98. Please list any sexual concerns you would like to discuss? _____		
99. What do you use for family planning or birth control? _____		

Family Apgar Assessment

Family here refers to relatives and close friends with whom you usually look to for continuing emotional support.

How satisfied are you with the way your family:	Always	Sometimes	Never
100. Helps you when you are in trouble?	☐	☐	☐
101. Discusses things and listens to your problems?	☐	☐	☐
102. Accepts your new interests or changes in your lifestyle?	☐	☐	☐
103. Expresses affection and responds to your feelings and moods?	☐	☐	☐
104. Spends time with you?	☐	☐	☐

	No	Yes
105. Are you concerned about physical violence or sexual abuse in your family?	☐	☐

Social Support

	No	Yes
106. Is there an imbalance between your work, family and leisure activities?	☐	☐
107. Is your relationship with your friends poorer than it was last year?	☐	☐
108. Is your relationship with your spouse/partner poorer than it was last year?	☐	☐
109. Is there someone with whom you can always discuss your personal problems?	☐	☐
110. Would you like patient education on any topics? If yes, which topics? _____	☐	☐

Medicare Patients Only

	No	Yes
111. Do you have an advanced directive or living will?	☐	☐
If yes, please provide us a copy for your chart.		
112. Do you have a healthcare proxy or surrogate decision maker?	☐	☐
If yes, please provide us a copy for your chart.		
113. Have you had any recent falls?	☐	☐
114. Have you fallen in the past year?	☐	☐
115. Do you use a cane or walker?	☐	☐
116. Are you able to dress yourself (including socks & shoes)?	☐	☐
117. Are you able to bathe and groom yourself?	☐	☐
118. Are you able to handle your finances	☐	☐
119. Able to obtain and take your own medications?	☐	☐
120. Are you able to get in and out of a car?	☐	☐
121. Can you go up and down steps?	☐	☐
122. Can you shop for yourself?	☐	☐
123. Are you able to prepare your own food?	☐	☐
124. Do you do your own housekeeping and laundry?	☐	☐
125. Do you drive a car?	☐	☐
126. Have you had trouble concentrating on things such as reading the newspaper or watching television?	☐	☐
127. Experienced a slowness in speaking or moving that someone else has noticed?	☐	☐
128. Have you or anyone else had concerns about your memory?	☐	☐

129. Please list any illnesses or hospital stays since last visit:

_____

_____

_____

_____

_____

130. Please list other providers involved in your medical care:

_____

_____

_____

_____

_____

Additional Comments or Questions

_____

_____

_____

_____

_____

_____

_____

Patient Signature

Signature: _____ Date: _____

For Office Use Only

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____