

**We want to know if you need help with any of the following, and who helps you.
Check and fill in for each task.**

<u>Task</u>	<u>Don't Need Help</u>	<u>Need Help</u>	<u>If you need help who helps?</u>
Feeding yourself	_____	_____	_____
Getting from bed to chair	_____	_____	_____
Getting to the toilet	_____	_____	_____
Getting dressed	_____	_____	_____
Bathing	_____	_____	_____
Using telephone	_____	_____	_____
Taking medication	_____	_____	_____
Preparing meals	_____	_____	_____
Managing money/ financial affairs/ checkbook	_____	_____	_____
Doing laundry	_____	_____	_____
Doing housework	_____	_____	_____
Shopping for food	_____	_____	_____
Driving	_____	_____	_____
Doing handyman work	_____	_____	_____
Climbing a flight of stairs	_____	_____	_____
Getting to places beyond walking distance	_____	_____	_____

Do you use a cane, walker, or wheelchair?

Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting?

Over the past few weeks, have you felt little interest or pleasure in doing things? NO__ YES__

Over the past 2 weeks, have you felt down, depressed or hopeless? NO__ YES__

Have you had previous problems with depression? NO__ YES__

Do you have any hearing or visual difficulties? NO__ YES__

Have you had any problems with your memory, or does a family member feel you have memory problems? NO__ YES__

Have you had any falls in the last year? NO__ YES__

Have you ever smoked cigarettes, pipe, cigar or chewed tobacco? NO__ YES__

What physical exercise do you regularly do?

Do you ever drink alcohol, including beer and/or wine? (check one)

- a. ____ Daily
- b. ____ Greater than 3 times a week
- c. ____ 1-3 times a week
- d. ____ Less than 1 time a week
- e. ____ Never

During the last month, what is the greatest number of alcoholic drinks you have consumed in one day? _____

Have you ever felt you have to cut down on your drinking? NO__ YES__

Have people annoyed you by criticizing your drinking? NO__ YES__

Have you ever felt bad or guilty about your drinking? NO__ YES__

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? NO__ YES__

Do you, or did you use any illicit drugs i.e. marijuana, cocaine, stimulants, etc. or overuse any prescription drugs i.e. sleeping pills, narcotics, etc.? NO__ YES__

Describe a typical day's food and beverage consumption.

In the past 12 months, have you ever lost control of your urine or gotten wet? NO__ YES__

Do you always wear a seatbelt when you ride in the car? NO__ YES__

Describe your residence and who lives with you. Do you employ someone to help you in your home?

Are you currently working, retired; what has been your principal occupation?

How much school did you complete?

Do you have a Living Will (Advanced Directive) and Medical Durable Power of Attorney (healthcare proxy)? NO__ YES__

Please describe any military service.

How important is religion or spirituality in your life?

For physician use: problem/risk factor list updated including FH _____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of the things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

- 0 – would **never** doze
- 1 – **slight** chance of dozing
- 2 – **moderate** chance of dozing
- 3 – **high** chance of dozing

<u>SITUATION</u>	<u>CHANCE OF</u>
<u>DOZING</u>	
Sitting and reading	_____
Watching TV	_____
Sitting inactive, in a public place (eg, a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

_____ 0-10, _____ 10-12, _____ 12-24

Which medical conditions do you have now, or have you had in the past?

(Check all that apply)

EYE AND EAR PROBLEMS

- a. cataracts
- b. glaucoma
- c. macular degeneration
of the eye
- d. sinus disease
- e. other, specify:

LUNG PROBLEMS

- a. asthma
- b. bronchitis
- c. lung cancer
- d. emphysema
- e. history or exposure to
tuberculosis or asbestos
- f. other, specify:

HEART PROBLEMS

- a. coronary bypass or stents
- b. atrial fibrillation
- c. coronary artery disease
- d. angina
- e. heart attack (year) _____
- f. heart failure
- g. passing out, fainting
- h. high blood pressure
- i. elevated cholesterol
- j. other, specify:

GASTROINTESTINAL PROBLEMS

- a. ulcers
- b. heartburn/hiatal hernia
- c. diverticulosis
- d. liver disease/ cirrhosis
- e. hepatitis
- f. polyps
- g. gallbladder disease
- h. other, specify:

BONE AND JOINT PROBLEMS

- a. arthritis
- b. osteoporosis
- c. fractured hip,
wrist or spine
- d. gout
- e. Raynaud's
- f. morning stiffness
- g. other, specify:

KIDNEY AND URINARY PROBLEMS

- a. kidney disease
- b. prostate disease
- c. bladder or kidney
infections
- d. blood in urine
- e. kidney stones
- f. other, specify:

GLAND PROBLEMS

- a. diabetes
- b. thyroid overactive (high)
- c. thyroid underactive (low)
- d. high calcium blood levels
- e. other, specify:

NERVOUS SYSTEM PROBLEMS

- a. stroke
- b. Parkinson's disease
- c. epilepsy/seizures
- d. neuropathy
- e. migraines
- f. other, specify:

OTHER HEALTH PROBLEMS

- a. anemia
- b. hernia
- c. thrombosis (blood clots)
- d. cancer, specify _____
- e. sexual function problem
- f. skin disease
- g. easy bruising or bleeding

Current Symptoms or Problems

To be certain that we've covered everything: during the last three months, have you had any of the following symptoms or problems? (Check all that apply)

EYE OR EAR PROBLEMS

- a. _____ ringing in ears
- b. _____ vertigo or spinning
- c. _____ ear trouble
- d. _____ other eye problems

HEART PROBLEMS

- a. _____ chest pain or tightness
- b. _____ rapid or irregular heart beats/palpitations

LUNG PROBLEMS

- a. _____ persistent cough
- b. _____ difficulty breathing or shortness of breath

BRAIN OR NERVOUS SYSTEM PROBLEMS

- a. _____ frequent headaches
- b. _____ frequent dizzy spells
- c. _____ passing out or fainting
- d. _____ paralysis, leg or arm weakness
- e. _____ numbness or loss of feeling anywhere
- f. _____ serious problem with memory or difficulty thinking
- g. _____ tremor or shaking

WOMEN'S PROBLEMS

- a. _____ vaginal bleeding
- b. _____ vaginal discharge
- c. _____ breast lumps or discomfort

DIGESTION PROBLEMS

- a. _____ dental problems
- b. _____ difficulty swallowing
- c. _____ frequent indigestion or stomach discomfort/pain
- d. _____ frequent nausea/vomiting
- e. _____ change in bowel habits
- f. _____ weight loss - how many pounds? _____
- g. _____ black bowel movements or bleeding from rectum
- h. _____ frequent diarrhea
- i. _____ persistent constipation

KIDNEY AND URINARY TRACT PROBLEMS

- a. _____ urination at night
- b. _____ frequent urination
- c. _____ difficulty starting or stopping urination

BONE AND JOINT PROBLEMS

- a. _____ leg pain on walking
- b. _____ back or neck pain
- c. _____ joint pain or stiffness
- d. _____ foot problems
- e. _____ leg pain in bed
- f. _____ joint swelling

OTHER HEALTH PROBLEMS

- a. _____ difficulty with sleeping
- b. _____ falling, stumbling or balance problems
- c. _____ swelling feet or ankles
- d. _____ fever or sweats
- e. _____ other

Family History

Please list all siblings and children:

Name	Age	Current health status	Health history

Please list your parents:

Name	Age	Current health status	Health history

Please list your grandparents:

Name	Age	Current health status	Health history

To the best of your knowledge, please list your parents' siblings and their children

Name	Age	Current health status	Health history