





**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>
<b><u>DOZING</u></b>	
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	_____
<b>TOTAL SCORE</b>	_____

---

\_\_\_\_\_ 0-10, \_\_\_\_\_ 10-12, \_\_\_\_\_ 12-24