Health Spring 360

Patient Name:_____ DOB:_____DATE:_____

Provider and Nurse completing:_____

Vitals: Height:_____Weight:_____BMI:_____BP:_____Temp:_____Pulse:_____Resp:_____

☑ **Annual Medication Review completed at this visit.**

Have you fallen this year or in the last 12 months?_____

During the last 3 months have you leaked urine (even a small amount)? Yes:_____ No:_____

Please assess the overall pain presence in your day-to-day life. 0 (no pain) - 10 (worse pain): _____

Have you done Advanced Care Planning? Living Will:_____ Medical POA:_____ Advanced Directive: _____

Activities of daily living screening	
1. Are you able to use a telephone without assistance?	□Yes □No
2. Are you able to shop for food and other necessities without help from others?	□Yes □No
3. Are you able to prepare simple meals by yourself?	□Yes □No
4. Are you able to dress, wash, and use the toilet without assistance?	□Yes □No
5. Are you able to transfer to and from bed and or chair without assistance?	□Yes □No
6. Are you able to do housework without assistance?	□Yes □No
7. Can you get to places outside of walking distance alone?	□Yes □No
8. Are you able to take your own medications and follow your diet correctly without help?	□Yes □No
9. Are you able to pay your bills and keep track of your check book balance and money without help?	□Yes □No

Depression Screening:

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
If you answered any of the above questions 1-3, how DIFFICULT have these problems made it for you to do your work, take care of things at home, or get along with other people?	0	1	2	3

Please list all specialists or other providers involved in your care (including eye doctors)

_____

_____

_____

_____

Date of your most recent:

COVID-19 1st dose: _____ **Brand Given:_____**

COVID-19 2nd dose: _____ **Brand Given:_____**

COVID-19 Booster: _____ **Brand Given:_____**

Flu Vaccine: _____ **Location Given:_____**

Pneumovax: _____ **Location Given:_____**

Prevnar 13: _____ **Location Given:_____**

Prevnar 20: _____ **Location Given:_____**

Bone Density: _____ **Location Performed:_____**

Pap Smear:_____ **Performed by Doctor:_____**

Mammogram:_____ **Location Performed:_____**

Colonoscopy: _____ **Location Performed:_____**

If patient has DM I or DM II answer next section:

Eye Exam: _____ **By Doctor: _____**

Microalbumin/creatinine/ratio **_____**

A1c **_____**

Does patient have Rheumatoid Arthritis? yes or no **Medication?_____**

Does patient have DM, CAD, or any type of high cholesterol? yes or no

Is patient on a statin? **yes or no** **Medication?_____**

******If not why? _____**