South Bay Medical Care – Yearly Assessment Tool for 2021

Patient Name: _____ DOB: _____ Age: _____

Thank you for your patience and diligence in answering this questionnaire and for allowing us to participate in your care. This form will assist us in providing the most comprehensive medical attention possible.

Smoking history			
Have you ever smoked?	□ Never	□ Former smoker Quit _____ (year) Smoked _____pks for #_____years	□ Current smoker _____ pks per day _____ # of yrs. smoking

Risk for Falls Screening – In the last year			
Have you had two or more falls in the last 12 months?		□ NO	□YES
Have you had a fall with injury?		□ NO	□YES
Do you have any problems with balance or gait?		□ NO	□YES
Office use only	**Any Yes above must have TUG Test =>12sec is at high risk for falling**	**TUG=_____ sec's**	**MD:____**

Alcohol Screening - Because alcohol use can affect your health and interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest. Place an X in the box that best describes your answer to each question.						
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	□ Never	□ Monthly or less	□ 2-4 times a month	□ 2-3 times A week	□ 7 or more times a week	
If the above answer is Never – stop, if YES, please complete remaining questions in this section						
How many drinks do you have on a typical day when you are drinking?	□ 1 or 2	□ 3 or 4	□ 5 or 6	□ 7 to 9	□ 10 or more	
How often do you have 6 or more drinks on one occasion?	□ Never	□ Less than monthly	□ Monthly	□ Weekly	□ Daily	
How often during the last year have you failed to do what was normally expected of you because of drinking?	□ Never	□ Less than monthly	□ Monthly	□ Weekly	□ Daily	
Has a friend or relative been concerned about your drinking and suggest you cut down?	□ No		□ Yes but not in the last year		□ Yes, during the last year	
Office use only (AuditC /LAST tests) >3	ADD COLUMNS	+	+	+	=	
Identifying Alcohol Use Disorders or at-risk drinking is score ≥3 or per Medicare If > 3 daily or ≥ 7 drinks weekly - pt counseled regarding alcohol moderation/ restraint					MD	

Function Screening		
Do you live alone?	□ NO	□YES
Do you need help with shopping or preparing meals?	□ NO	□YES
Do you need help with taking your medicine or other daily activities?	□ NO	□YES

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Do you need help with managing your finances?	□ NO	□YES

Drug Abuse Screening (DAST-10) – Please Answer Yes or No – In the past 12 months :		
Have you used drugs for any non-medical use and/or used illegal medications/drugs	□ NO	□YES
Have you used prescribed medications in excess of the directions	□ NO	□YES
If the both above answers are NO – stop, If either or both are YES - complete remaining questions in this section.		
Have you used drugs other than those required for medical reasons?	□ NO	□YES 1
Do you use more than 1 drug at a time?	□ NO	□YES 1
Are you always able to stop using drugs when you want to?	□ NO 1	□YES
Have you had "blackouts" or "flashbacks" as a result of drug use?	□ NO	□YES 1
Do you ever feel bad or guilty about your drug use?	□ NO	□YES 1
Does your family or friends ever complain about your involvement with drugs?	□ NO	□YES 1
Have you neglected your family or friends because of your drug use?	□ NO	□YES 1
Have you engaged in illegal activities in order to obtain drugs?	□ NO	□YES 1
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	□ NO	□YES 1
Have you had medical problems as a result of your drug use (i.e. memory loss, hepatitis, convulsions, bleeding, etc.)?	□ NO	□YES 1

	Office use only	No score 0-1 Yes score 0-9 add together	_____+	_____	=

Advance Care Planning – Sometimes decisions must be made about the use of emergency treatments to sustain life. There are several artificial or mechanical ways to try and do this. Decisions that might come up would relate to: CPR, Ventilator use, Artificial nutrition (tube feeding and artificial hydration (intravenous fluids), and Comfort care to name a few. □ This is not applicable to me

Do you already have advance directives completed, i.e. MOLST or DNR/DNI forms? If yes, please provide the office with a copy.	□ NO	□YES
Do you already have a health care proxy? If yes, please provide the office with a copy.	□ NO	□YES
Would you like to execute Advanced Care Planning documents at this visit? If not, please ask to discuss if your situation changes at any point.	□ NO	□YES

	OFFICE Use Only	Advanced Directive Completed today and is in chart	MD

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Depression Screening			
Over the past two weeks, have you felt down, depressed or hopeless?		□ NO	□YES
Over the last two weeks, have you felt little interest or pleasure in doing things?		□ NO	□YES
Office use only	**If either question above is Yes please have pt complete a PHQ9 form**	**PHQ9 Score:_____**	**MD:_____**

PHQ9 SCREENING

Part of routine screening for your health includes reviewing mood and emotional concerns. You have answered "Yes" to one or more of the screening questions or have a previous diagnosis of depression.

Please answer each question below by checking ONE box per question.

During the past two weeks, how often have you been bothered by any of the following?	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
Feeling down, depressed, irritable or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss or overeating				
Feeling tired or having little energy				
Feeling bad about yourself – or feeling that you are a failure or have let yourself or your family down				
Trouble concentrating on things, like reading the newspaper or watching television				
Moving or speaking so slowly that other people possibly noticed? Or being so fidgety or restless that you were moving around a lot more than usual?				
Thoughts that you would be better off dead or of hurting yourself in some way				
If you are experiencing any of the problems on this form, 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? □Not difficult at all □Somewhat difficult □Very difficult □Extremely difficult				

For Office Use only:
Total Score: _____
Total =>9 please document treatment/assessment/referral

□ Hx. of depression, under care
□ FU plan i.e. meds, referral etc. in chart
□ Score discuss, no treatment needed
MD Signaure:

_____

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SB forms- depression PHQ9 form

I acknowledge that I understand that for those over age 40 Colonoscopy and Mammograms are suggested and >50 they are recommended. □ This is not applicable to me	
When was your last Colonoscopy?	□_____/_____/_____ Dr:_____ □ Never □ I do not wish to have done at this time
When was your last Mammogram?	□ _____/_____/_____ Facility/Doctor Name:_____ □Never □ I do not wish to have done at this time

	Office Use Only: If patient says yes and a copy of report is not in chart, please call and ask that a copy be faxed over	
	□ Colonoscopy report requested from Dr:_____ by_____	□Received /____
	□ Mammogram report requested from _____ by_____	□Received /____

Vaccine History – I acknowledge that the CDC recommends yearly Flu Shots and one dose of Pneumonia vaccine. This is especially true for those who are >65 yrs. old, those who work in the medical industry and immunocompromised patients.		
Did you have a FLU vaccine in the last year? (Sept through March)	□Yes When_____ Where? _____	□No - and I do not wish one
Have you had a Prevnar 13 Pneumonia Vaccine	□Yes When_____ Where? _____	□ No – and I do not wish one
Have you had the Pnemo 23 Vaccine?	□Yes When_____ Where? _____	□ No – and I do not wish one
Have you had a Tetanus vaccine recently? Tdap, TD	□Yes When_____ Where? _____	□No – and I do not wish one

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Patient Signature: _____ Date: _____/_____/2021

Physician Signature: _____ Date: _____/_____/2021