# ANNUAL SENIOR HEALTH ASSESSMENT

Thank you for taking the time to complete this survey.
The answers you give will be shared with your doctor and will help you to receive the best possible care.

| | | | |
|---|---|---|---|
| **Patient Last Name:** | | **Date of Birth:** | M M / D D / Y Y Y Y |
| **Patient First Name:** | | **Today's Date:** | M M / D D / Y Y Y Y |
| **Street Address:** | | **Medicare ID:** | |
| **Zip:** | | **Preferred Phone #:** | ( ) - |

**Patient Instructions:** *Please answer the questions by checking the box like this:* ○ Yes ✓ No *Thank you!*

| | | ***This Column For Provider Use*** |
|---|---|---|
| 1. | **In general, how would you rate your overall health?**<br>○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor | |
| 2. | **Do you currently take a daily ASPIRIN?** ○ Yes ○ No | If patient answered "No" please indicate one of the following:<br>☐ Prescribed Aspirin<br>☐ Patient Declined Treatment<br>☐ Aspirin Contraindicated<br>☐ Other |
| 3. | **Have you had a recent FLU VACCINE?**<br>○ Yes ○ No If "Yes", please indicate Month/Year:<br>☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec — ○ 2013<br>☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun<br>☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec — ○ 2014 | ☐ Provided Influenza Vaccine<br>☐ Patient Declined Vaccination<br>☐ N/A due to Flu Shot Allergy<br>☐ Other |
| 4. | **Have you ever had a PNEUMONIA vaccine? Approximate Date:**<br>○ Yes ○ No M M / D D / Y Y Y Y | ☐ Provided Pneumonia Vaccine<br>☐ Patient Declined Vaccination<br>☐ N/A due to Pneumovax Allergy<br>☐ Other |
| 5. | **If you are between 50 - 75 years old, have you had screening for COLORECTAL CANCER in the last 10 years?**<br>○ Yes ○ No ○ N/A due to Total Colectomy<br>*If yes, what type of screening test:*<br>○ FOBT (Fecal Occult Blood Test)<br>○ Flexible Sigmoidoscopy<br>○ Colonoscopy<br>**Approximate Date:** M M / D D / Y Y Y Y | ☐ Prescribed FOBT/FIT Test<br>☐ Referred for:<br>☐ Colonoscopy<br>☐ Flexible Sig/BE<br>☐ Patient Declined Intervention<br>☐ N/A due to Total Colectomy<br>☐ N/A due to Hx of Colon Cancer<br>☐ Other |
| 6. | **Have you had a RETINAL EYE EXAM by an Eye Care Professional in the last 2 years?**<br>○ Yes ○ No ○ N/A<br>**Approximate Date:** M M / D D / Y Y Y Y | ☐ Referred to:<br>☐ Ophthalmology<br>☐ Optometry<br>☐ Other |
| 7. | **If you are a FEMALE between 50 - 74 years old, have you had a MAMMOGRAM in the last 27 Months (2 years & 3 months)?**<br>○ Yes ○ No<br>○ N/A due to Total Mastectomy<br>**Approximate Date:** M M / D D / Y Y Y Y | Mammogram Result:<br>○ Normal ○ Abnormal<br>☐ Referred for:<br>☐ Mammogram<br>☐ N/A due to Bilateral Mastectomy<br>☐ Other |
| 8. | **For patients with a chronic pain condition:**<br>**During the past 4 weeks, to what degree have you felt body pain?**<br>○ None ○ Very Mild ○ Mild ○ Mod ○ Severe | ☐ Monitor & Counseling<br>☐ Referred to Pain Mgmt.<br>☐ Prescribed Pain Medicine<br>☐ Other |

# ANNUAL SENIOR HEALTH ASSESSMENT

Patient Last Name: | Medicare ID: | DOB: M M / D D / Y Y Y Y

| | | |
|---|---|---|
| 9. | **Over the past 2 weeks how often have you been bothered by any of the following problems:**<br>**PHQ-2 Questions** / **Not at All** / **Occasionally** / **Frequently** / **Daily**<br>**Little interest or pleasure in doing things?** 0 / 1 / 2 / 3<br>**Feeling down, depressed, or hopeless?** 0 / 1 / 2 / 3 | Total PHQ-2 Score: (A PHQ-2 Score >3 is Positive)<br>☐ Recommended PHQ-9<br>☐ Monitor & Counseling Provided<br>☐ Rx Given For Antidepressant<br>☐ Other |
| 10. | **How often is ANXIETY or STRESS a problem for you in handling your Health, Finances, Family, Work, or Social Relationships?**<br>○ Not at All ○ Occasionally ○ Frequently ○ Daily | ☐ Referred to:<br>☐ Behavioral Health<br>☐ Counseling<br>☐ Social Services<br>☐ Case Management<br>☐ Rx Given For Anxiolytic<br>☐ Other |
| 11. | **In the past 7 days, have you needed help from others to:**<br>Eat, dress, bathe, or use the toilet? ○ Yes ○ No ○ N/A | ☐ Referred to Social Services<br>☐ Referred to Case Management<br>☐ Other |
| 12. | **In the past 7 days, have you needed help from others to:**<br>Do laundry, housekeeping, or shopping? ○ Yes ○ No ○ N/A | ☐ Referred to Social Services<br>☐ Referred to Case Management<br>☐ Other |
| 13. | **In the past 6 months, have you had any problems with URINARY INCONTINENCE (leaking of urine)?** ○ Yes ○ No ○ N/A | ☐ Rx Given For Incontinence<br>☐ Referred to Urology<br>☐ Other |
| 14. | **In the <u>past 12 months,</u> have you had any problems with BALANCE, WALKING, or had any FALLS?** ○ Yes ○ No ○ N/A | ☐ Fall Prevention Counseling<br>☐ Rx Given For Cane<br>☐ Referred to Physical Therapy<br>☐ Referred for Vision/Hearing Eval.<br>☐ High Risk Medications Reviewed<br>☐ Other |
| 15. | **Are you currently a SMOKER or use any TOBACCO products?** ○ Yes ○ No | ☐ Counseled on Tobacco Cessation<br>☐ Patient Declined Intervention<br>☐ Rx Given (e.g. Nicotine Patch)<br>☐ Refer: ☐ Behavioral ☐ Case Mgmt.<br>☐ Other |
| 16. | **Do you consume 2 or more ALCOHOL containing drinks per day?** ○ Yes ○ No | ☐ Counseled on Alcohol Cessation<br>☐ Patient Declined Intervention<br>☐ Rx Given<br>☐ Refer: ☐ Behavioral ☐ Case Mgmt.<br>☐ Other |
| 17. | **Do you EXERCISE or do moderate physical activity such as walking for at least ½ hour a day?** ○ Yes ○ No | ☐ Discussed Modification of Diet<br>☐ Discussed Exercise & Lifestyle<br>☐ Patient Declined Intervention<br>☐ Referred to PT/OT<br>☐ Other |
| 18. | **Do you have an ADVANCED DIRECTIVE, LIVING WILL, or POLST?** ○ Yes ○ No | ☐ Advanced Care Plan Reviewed<br>☐ Patient Declined Intervention<br>☐ Refer:<br>☐ Palliative Care<br>☐ Hospice<br>☐ Reviewed POLST Form<br>☐ Other |

# ANNUAL SENIOR HEALTH ASSESSMENT

Patient Last Name: | Medicare ID: | DOB: M M / D D / Y Y Y Y

***Doctor's Office: Please indicate the most recent values for the following:***

| | | | |
|---|---|---|---|
| **Pt.'s Conditions** | ☐ DM ☐ CHF* ☐ CAD ☐ HTN ☐ IVD** | | *(For Provider Use)* *Chronic Condition Interventions* |
| **Weight** | lbs. | **LDL-C Result** | ☐ Rx Aspirin ☐ Rx ACE/ARB |
| **Height** | in. | **LDL Date:** M M / D D / Y Y Y Y | ☐ Rx ß-Blocker ☐ Rx Statin |
| **BMI** | | **HgbA1C Result** . ☐ N/A | ○ BP < 140/90, Screen in 1 yr. |
| **Blood Pressure** | / | **HgbA1C Date:** M M / D D / Y Y Y Y ☐ N/A | ○ BP > 140/90, Screen in 1 mo |
| **Medication Review** | ☐ Medication List is present in the Medical Record | ☐ Medications Reviewed by Prescriber or Pharmacist | ☐ Assessed Cognitive Status<br>☐ Assessed Ambulation Status<br>☐ Assessed Sensory Ability |

*CHF: For patients with LVSD (Left Ventricular Systolic Dysfunction) **IVD = Ischemic Vascular Disease, including PVD, & CVD

| Physician Last Name | Reviewer Last Name |
|---|---|
| | |
| **Physician NPI** | **Reviewer Signature** |
| | |
| **Physician E-mail** | **Date Reviewed** |
| | M M / D D / Y Y Y Y |