Name_____ **Health Assessment** **Date** _____

In the past 4 weeks, have you had **trouble** with the following:

__Doing usual activities or tasks because of your physical and emotional health?
__Being bothered by emotional problems such as feeling anxious or depressed?
__Limited social activities because of your physical or emotional health?
__Pain in your body? How much? _____
__Having someone to help you if you needed or wanted help?

Do you have any **trouble** doing the following without help?

__Get to places out of walking distance?
__Go shopping for groceries or clothes without help?
__Prepare meals?
__Do housework?
__Meet personal hygiene needs?
__Handle your own finances?

Overall Health

How would you rate your health? Poor 1 2 3 4 5 Excellent
How have things been going for you in the past 4 weeks? Poor 1 2 3 4 5 Excellent
__Do you feel unsafe driving your car?
__Do you forget to wear a seatbelt when you are in a car?
__Do you struggle financially to buy the things that you need(food, clothing, housing)?
__Have you fallen 2 or more times in the past year?
__Are you afraid of falling?
__ Do you believe your medications are making you ill?
__In the past 3 months did you have an illness or injury that kept you in bed for all or most of the day?
__In the past year did you stay in a hospital overnight or longer?
__Do you smoke?
__Do you drink wine, beer or other alcoholic beverages? How much? _____
Do you exercise for about 20 minutes 3 or more days a week? Yes No
What is the hardest physical activity you can do for at least 2 minutes? _____

In the past 4 weeks, have you been **bothered** by any of the following problems?

__Trouble thinking or remembering
__Trouble urinating or wetting
__Trouble hearing
__Trouble seeing
__Falling or dizzy when standing up
__Sexual problems
__Trouble sleeping
__Foot problems
__Constipation
__Trouble eating well
__Teeth or denture problems?

Has a doctor told you that you have any of the following problems?

__High blood pressure?
__Heart trouble or hardening of arteries?
__(Sugar) Diabetes?
__Arthritis?

__Asthma, bronchitis or emphysema?

__Serious obesity (more than 15% overweight)?

Do you use any of the following?

__Cane, wheelchair or walker?

__Brace or prosthesis?

__A hearing aid?

__Dentures?

__Reading glasses?

__Raised toilet seat, bathtub bars, toilet bars?

__Devices for dressing, eating or bathing?

__Emergency alert system

During the past 4 weeks, have you seen any of the following health care workers?

__None

__Your own or another doctor?

__Home health aid or nurse in your home?

__Social Worker?

__Podiatrist?

__Chiropractor?

__Mental health worker(psychiatrist, psychologist)?

__Physical Therapist or occupational therapist?

__Nurse practitioner or physician's assistant?

Yes No

Wellness

How much do you weigh? _____ How tall are you? _____

Have you had a pneumonia shot in the past 5 years? Yes No

Do you receive a flu shot every year? Yes No

Have you had a tetanus shot in the past 10 years? Yes No

In the past two years have you had:

A Colonoscopy? Yes No

A test for cholesterol? Yes No

Good education about the advantages and disadvantages of a blood test for prostate cancer? Yes No

__Check here if you want information to help you with potential hazards in your home.

__Check here if you want information to help you with keep track of your medications.

__Check here if you have trouble taking medicines the way you have been told to take them.

If you became too sick to speak for yourself, who would decide about your medical treatment?_____

If so, does he or she know what you want? Yes No

Is it in writing? Yes No

Are you confident that you can control and manage most of your health problems? Yes No

Do you have one person you think of as your personal doctor or nurse? Yes No

When you visit your doctor's office, how well is it organized? Disorganized 1 2 3 4 5 Organized

How easy is it to receive medical care when you need it? Not easy 1 2 3 4 5 Very easy

Do you see a specialist for any other health problems? Yes No

How many different prescription medications are you currently taking more than 3 days a week? _____

What is the highest grade level of school you have completed?_____

Demographics

White Black or African American Asian Hawaiian American Indian Hispanic Other