

Aurora Family Medicine Center, P.C.

Patient Name: _____

Date: _____

Date of Birth: _____

Dr. or P.A. seeing you today: _____

- I have a: Living Will Medical Order for Life Sustaining Treatment Medical Power of Attorney
 Other: _____
 I'm interested in learning more about these forms for documenting my wishes for end of life decision-making

Depression Screening:

In the last two weeks, circle how often you have been bothered by the following:	Not at all	Several days	More than half the days	Nearly every day
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
Add columns for total score:	0 pts.			

If you checked off *any* problems, 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

Patient Signature: _____

For office Use Only

Cognition screen prompts Mini-Cog

Three word registration score: _____

Clock drawing score: _____

Three word recall score: _____

Mini-Cog Score, note documented in EMR:

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Medical history/Family history

	Me	Father	Mother	Siblings	Children	Specify Condition
Heart Disease						
Aneurysms						
High Blood Pressure						
High Cholesterol						
Stroke						
Kidney Disease						
Cancer						
Diabetes						

Activities of Daily Living

Do you require assistance with any of the following activities?

- | | | | | | |
|----------------------------|------------------------------|-----------------------------|---------------------------|------------------------------|-----------------------------|
| Using the telephone | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eating | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shopping | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Getting from bed to chair | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Meal preparation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dressing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Housekeeping | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Laundry | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Toileting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Driving/taking taxi or bus | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Continence | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Taking medications | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Handling finances | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

I have someone available to help if needed (for a sick day) Yes, any time Yes, sometimes Not really

Accident Prevention:

- Do you wear seatbelts in the car? Yes No
- Do you have smoke detectors at home? Yes No
- Do you have carbon monoxide detectors? Yes No
- Do you have a firearm at home? Yes No If yes, is it locked up? Yes No

Health Screening: Substance Use, Diet, Exercise, Fall Risk

- Do you drink alcohol? Yes No _____ drinks per day / week (circle one) I no longer drink alcohol
- Have you ever smoked or chewed tobacco? Yes No Currently use how much: _____ per day
- Do you use marijuana or illicit drugs? Yes No I'm interested in help to stop using _____
- Diet: balanced vegetarian diabetic low salt low fat low carb other: _____
- Do you exercise every day? Yes No If not, how often do you exercise? _____
- Have you had any falls in the past year? Yes No If yes, any injuries? _____
- Do you have trouble hearing? Yes No Do you have trouble seeing? Yes No
- Do you wear a hearing aid? Yes No Do you wear glasses or contacts? Yes No
- Last hearing exam: _____ Last eye exam by optometrist or ophthalmologist: _____
- Personal concern about memory or family mentions concern Yes No

Office Use: Referral PHP Care Coordinator Referral

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Please list current medications and dosage

Medication	Dosage	Reason for taking

Please list any NEW known allergies

Medication	Reaction

Please list all other medical providers/specialists you see regularly

Specialist	Reason