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:_____ Mini-Cog Score, note documented in EMR: ☐

Clock drawing score:_____

Three word recall score:_____

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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	☐Yes	☐No	Eating	☐Yes	☐No
Shopping	☐Yes	☐No	Getting from bed to chair	☐Yes	☐No
Meal preparation	☐Yes	☐No	Dressing	☐Yes	☐No
Housekeeping	☐Yes	☐No	Bathing	☐Yes	☐No
Laundry	☐Yes	☐No	Toileting	☐Yes	☐No
Driving/taking taxi or bus	☐Yes	☐No	Continence	☐Yes	☐No
Taking medications	☐Yes	☐No			
Handling finances	☐Yes	☐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

Do you have an eye doctor/specialist? Yes No

If yes, name of doctor or business name:_____