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.

Name: _____ **ID Number:** _____

Date of Birth: ____/____/____ **Age:** _____ **Phone Number:** _____

Address: _____ **Today's Date:** ____/____/____

_____ **Preferred Language:** _____

Race/Ethnicity: ☐ American Indian ☐ Asian ☐ Hispanic ☐ Black or African American
☐ Native Hawaiian ☐ White ☐ Pacific Islander ☐ Other _____

Completed by: _____ **Relationship:** _____

Instructions:

- *Please answer the questions by checking the box like this:* ☐ Yes ☑ No
- *For questions without a check box, please write your response on the line provided. Thank you!*

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1. **In general, how would you rate your health?**
   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
2. **Do you have any bothersome health problems?** ☐ No ☐ Yes (*Check all that apply*)
   ☐ Diabetes ☐ Kidney Problems ☐ Alzheimer's / Dementia
   ☐ Stroke ☐ Liver Problems ☐ COPD (Lung Disease)
   ☐ Heart Problems ☐ Transplant (Type): _____
   ☐ Impotence or low sexual desire ☐ Other(s): _____
   ☐ Cancer (Type): _____ _____
3. **In the <u>past 7 days</u>, did you need help from others to perform everyday activities such as** *eating, getting dressed, grooming, bathing, walking,* or *using the toilet***?** ☐ No ☐ Yes
   If "Yes", please describe: _____
   _____
4. **In the <u>past 7 days</u>, did you need help from others to take care of things such as** *laundry, housekeeping, shopping, using the telephone, food preparation, transportation,* or *taking your medications*?
   ☐ No ☐ Yes
   If "Yes", please describe: _____
   _____
5. **Do you use any of the following items?** ☐ No ☐ Yes (*Check all that apply*)
   ☐ Oxygen ☐ Wheelchair ☐ Hospital Bed
   ☐ Diapers/Incontinence Supplies ☐ Walker/Cane ☐ Catheter
6. **In the <u>past 12 months</u>, how many times have you been a patient in a HOSPITAL where you stayed overnight?** ☐ Not at all ☐ 1 time ☐ 2 times or more
7. **In the <u>past 6 months</u>, how many times did you go to the EMERGENCY ROOM at a hospital?**
   ☐ Not at all ☐ 1 time ☐ 2 times or more
8. **Have you had SURGERY in the <u>past 12 months</u>?** ☐ No ☐ Yes
   If "Yes," what type did you have? _____
9. **How many PRESCRIPTION MEDICATIONS do you take?** ☐ None ☐ 1-5 ☐ 6 or more
10. **Do you take a daily ASPIRIN?** ☐ Yes ☐ No

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11. **Did you get a FLU VACCINE this past flu season?** ☐ Yes ☐ No
   a. *Approximate Date*: MM / DD / YYYY

12. **Have you ever had a PNEUMONIA vaccine?** ☐ Yes ☐ No
   a. *Approximate Date*: MM / DD / YYYY

13. **Have you been screened for COLORECTAL CANCER in the last 10 years?** ☐ Yes ☐ No
   If yes, what type of test:
   a. ☐ FOBT (Fecal Occult Blood Test) *Approximate* Date: MM / DD / YYYY
   b. ☐ Flexible Sigmoidoscopy *Approximate* Date: MM / DD / YYYY
   c. ☐ Colonoscopy *Approximate* Date: MM / DD / YYYY

14. **Have you had a GLAUCOMA SCREENING in last 2 years?** ☐ Yes ☐ No
   a. *Approximate* Date: MM / DD / YYYY

15. (*Women Aged 40-69*) **Have you had a MAMMOGRAM in the last 2 years?** ☐ Yes ☐ No
   a. *Approximate* Date: MM / DD / YYYY

16. **Do you have an ADVANCED DIRECTIVE, Living Will or POLST?** ☐ Yes ☐ No

17. **In the past 7 days, how many servings of each of the below foods did you typically eat each day?**
   a. Fruits and vegetables _____ servings / day
   b. High fiber or whole grain foods _____ servings / day
   c. Fried or high-fat foods _____ servings / day
   d. Sugar-sweetened (not diet) beverages _____ servings / day

18. **How would you describe the condition of your mouth and teeth, including false teeth or dentures?**
   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

19. **Have you ever SMOKED cigarettes, a pipe or cigars, or chewed tobacco?** ☐ Yes ☐ No
   a. If "*Yes*", are you currently smoking or using tobacco? ☐ Yes ☐ No
   b. If "*Yes*", would you like assistance to stop using tobacco? ☐ Yes ☐ No

20. **During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?**
   ☐ 10 or more per ☐ 6-9 per week ☐ 2-5 per week ☐ 1 drink or less per week

21. **Do you EXERCISE or do moderate physical activity such as walking 5 days a week?** ☐ Yes ☐ No

22. **Have you had any problems with BALANCE or WALKING in the past 12 months?** ☐ Yes ☐ No

23. **Have you had any FALLS in the past year?** ☐ No ☐ Yes If "*Yes*", how many? _____
   a. If "Yes", what caused your FALL? _____
   b. Do you live alone? ☐ Yes ☐ No
   c. Do you have stairs in your home? ☐ Yes ☐ No
   d. Do you have carpet flooring? ☐ Yes ☐ No
   e. Do you have area rugs? ☐ Yes ☐ No

24. **Many people experience problems with URINARY INCONTINENCE, the leakage of urine:**
   a. In the past 6 months, have you accidentally leaked urine? ☐ Yes ☐ No
   f. If "*Yes*", would you like to discuss treatment options? ☐ Yes ☐ No

25. **During the past 4 weeks, how much bodily pain did you generally have?**
   ☐ No Pain ☐ Very mild pain ☐ Mild Pain ☐ Moderate Pain ☐ Severe Pain

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26. Over the past 2 weeks how often have you been bothered by any of the following problems:

	Not at all	Several Days	More Than Half the Days	Nearly Every Day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed or hopeless	0	1	2	3

27. Are you being treated for DEPRESSION with medication? ☐ Yes ☐ No

28. How often is ANXIETY or STRESS a problem for you in handling the following things:

	Not at all	Several Days	More Than Half the Days	Nearly Every Day
a. Your Health	0	1	2	3
b. Your Finances	0	1	2	3
c. Your Family or Social relationships	0	1	2	3
d. Your Work	0	1	2	3

29. Do you experience any of the following on a regular basis?

a. Getting lost when going for a walk or driving ☐ Yes ☐ No
b. Forgetting appointments, family occasions, or holidays ☐ Yes ☐ No
c. Becoming more forgetful or can't remember things that happened recently ☐ Yes ☐ No
d. Having trouble finding the words you want to say or naming people and things ☐ Yes ☐ No

30. How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Never

31. Do you always fasten your seat belt when you are in a car? ☐ Yes ☐ No

32. Do you have smoke detectors in your home? ☐ Yes ☐ No

33. Do you have carbon monoxide detectors? ☐ Yes ☐ No

To Be Completed by the Doctors Office

Weight:	*Lbs.*	**Height:**	*Ft.*	*In.*	**LDL-C:**	**Date:**	MM / DD / YYYY
BMI:		**BP:**	/		**A1c Result:**	**Date:**	MM / DD / YYYY

☑ **Addressed**	☑ **Addressed (*as applicable)*:**
☐ Health Promotion: Diet & Exercise (#17, 21)	☐ Tobacco Cessation Plan (#19)
☐ Medication Review (#9, 10)	☐ Urinary Incontinence Plan (#24)
☐ Fall Prevention (#22, 23)	☐ Pain Management Plan (#25)
☐ Preventive Care (#11, 12, 13, 14, 15)	☐ Depression Management Plan(PHQ-2) (#26, 27)
☐ Advanced Care Planning (#16)	☐ Weight Management Plan for BMI <22 or ≥ 30
Refer for Care Management services ☐ Yes ☐ No	Patient received Anticipatory Guidance ☐ Yes ☐ No
Physician ID	**Physician Name (*Print*)**
Date Completed	**Reviewed by (*Signature Required*)**
MM / DD / YYYY	

FAX COMPLETED FORM TO 949-923-3528
(FOR MONARCH PIONEER ACO & Medicare Advantage SENIORS *ONLY*)