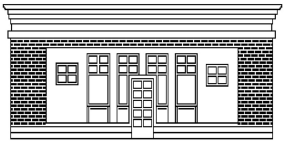
Mount Airy Family Practice



A pentahealth Practice

760 Carpenter Lane
Philadelphia, PA 19119
215-848-6880
mafp@mtairyfp.com

DATE OF VISIT: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

MEDICARE ANNUAL WELLNESS VISIT SELF-ASSESSMENT FORM

Please answer the following questions based upon how you have been doing in the past four weeks. Your answers will help us identify areas to address and provide you with the best possible healthcare.

1.	How does your physical health compare to last year?	☐ Worse	☐ Same	☐ Better
2.	How does your emotional health compare to last year?	☐ Worse	☐ Same	☐ Better
3.	Has your physical or emotional health limited your activities with family, friends, neighbors, or groups?	☐ Most of the time	☐ Often	☐ Not at all
4.	On a scale of 0 (no pain) to 10 (most severe pain imaginable), what level of pain do you experience on a daily basis? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10			

Activities of Daily Living

5.	Can you travel independently by bus, taxi/ride-share (e.g. Uber), or drive your own car?	☐ YES	☐ NO
6.	Can you do your own housekeeping without help?	☐ YES	☐ NO
7.	Can you prepare your own meals?	☐ YES	☐ NO
8.	Can you handle your own money without help?	☐ YES	☐ NO
9.	Do you have hearing issues or require a hearing aid?	☐ YES	☐ NO
10.	Do you need glasses or contacts for routine vision?	☐ YES	☐ NO
11.	Do you have any difficulty with eating or meal preparation?	☐ YES	☐ NO
12.	Do you have any difficulty with bathing or grooming?	☐ YES	☐ NO

Fall Risks

13.	Have you fallen two or more times in the past year?	☐ YES	☐ NO	
14.	Are you afraid you will fall?	☐ YES	☐ NO	
15.	Have you been bothered recently by dizziness when standing up?	☐ YES	☐ NO	
16.	How do you move around?	☐ Independently	☐ I am unsteady	☐ With a cane or walker ☐ Wheelchair ☐ Bed-bound

Lifestyle/Behavior

17. How many times do you exercise per week? ☐ Never ☐ 1-2 ☐ 2-3 ☐ 4+

18. Have you leaked urine in the past 6 months? ☐ YES ☐ NO

19. In the past 2 weeks, did you miss any doses of your medicines? ☐ YES ☐ NO

20. How often do you miss doses of your medicines? ☐ Never ☐ A few times a year ☐ A few times a month ☐ A few times a week ☐ Frequently

21. Which factors keep you from taking your medicine as directed?
☐ Forgetfulness ☐ Side Effects ☐ Cost
☐ Do not understand the directions ☐ Do not think it is necessary
☐ Do not think it helps ☐ Other:

22. Do you currently smoke cigarettes or use tobacco products? ☐ YES ☐ NO

23. If you have ever used tobacco products, in what year did you start? _____

If you smoked, how many packs per day did you use? _____

If you quit using tobacco, in what year did you quit?

Resources

24. Do you have an advance directive or living will? ☐ YES ☐ NO

25. Would you have someone to help you if you were ill and needed help with chores, emotional support or companionship, or care in your home?
☐ Yes, as much help as I need ☐ Yes, some help ☐ No, I have no one who can help me

26. How confident are you that you can control and manage most of your health problems?
☐ Very Confident ☐ Somewhat confident ☐ Not very confident ☐ I have no health problems

27. Do you have any social or financial concerns? ☐ YES ☐ NO

Satisfaction with Access

28. Are you satisfied with your access to appointments at our office? ☐ YES ☐ NO

29. Are you satisfied with the care or treatment you receive here? ☐ YES ☐ NO

30. Are there barriers to receiving care that you would like addressed? ☐ YES ☐ NO

Provider (printed): _____ Provider Signature: _____

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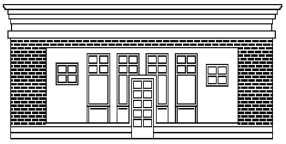

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PATIENT HEALTH QUESTIONNAIRE 9 (PHQ-9)

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
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 asleep, 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're a failure or have let yourself & 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
	Column Totals:				
	Add Column Totals Together:				

If you checked off any problems above…

10. How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not At All ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

11. How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4+ times per week

12. How many standard drinks containing alcohol do you have on a typical day?

☐ 0, 1, or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

13. How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

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