

## HAMPDEN MEDICAL GROUP HEALTH ASSESSMENT FORM

### Patient Information

Name \_\_\_\_\_

DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### General Health

- In general, would you say your health is:  
Excellent    Very Good    Good    Fair    Poor
- How would you describe the condition of your mouth and teeth – including false teeth or dentures:  
Excellent    Very Good    Good    Fair    Poor
- In the past 7 days did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?    Yes                      No
- In the past 7 days, did you need help from others to take care of things such as laundry, housekeeping, banking, shopping, cooking, or taking medications?                      Yes                      No
- In the past 7 days how much pain have you felt?    None                      Some                      A lot
- How often do you get the social and emotional support you need?  
Always              Usually              Sometimes              Rarely              Never

### History of Chronic Diseases

Have you been diagnosed with any of the following:

Asthma	Yes	No	Diabetes	Yes	No
Cerebrovascular Incident (stroke)	Yes	No	Emphysema	Yes	No
COPD	Yes	No	Heart Disease	Yes	No
Depression	Yes	No	What type? _____		
			High Blood Pressure	Yes	No

Do you have any other chronic diseases that require ongoing treatment?    Yes    No

Please list them: \_\_\_\_\_  
\_\_\_\_\_

### Injury Risks

Do you live alone?	Yes	No	Do you have stairs in your home?	Yes	No
Do you have carpet flooring?	Yes	No	Do you have area rugs?	Yes	No
Do you ever feel unsteady when you walk?	Yes	No	Do you feel dizzy or lightheaded?	Yes	No
Do you feel you are at risk for falling?	Yes	No	Do you fall often?	Yes	No

When was the last time you fell? \_\_\_\_\_  
What caused you to fall? \_\_\_\_\_

Do you have smoke detectors in your home?	Yes	No	Do you have animals in your home?	Yes	No
Do you have carbon monoxide detectors?	Yes	No	Do you have firearms in your home?	Yes	No
Do you drive?	Yes	No	Do you wear seatbelts?	Yes	No
Do you feel you can safely operate a car?	Yes	No	Do you ever drive after drinking?	Yes	No

**Social/Lifestyle Habits**

Do you smoke? Yes No If yes, what and how often? \_\_\_\_\_  
If yes, are you interested in quitting? Yes No  
Do you use other tobacco? Yes No If yes, what and how often? \_\_\_\_\_  
If yes, are you interested in quitting? Yes No  
Do you drink caffeine? Yes No How much? \_\_\_\_\_  
Do you drink alcohol? Yes No How often? \_\_\_\_\_  
Do you take illicit drugs? Yes No If yes, what? \_\_\_\_\_  
Do you exercise? Yes No How often and what do you do? \_\_\_\_\_

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Do you snore? Yes No How many hours of sleep do you get per night? \_\_\_\_\_  
Do you have any problems sleeping? Yes No If yes, what? \_\_\_\_\_  
• In the past 7 days, how often have you felt sleepy during the daytime?  
Always Usually Sometimes Rarely Never

Do you eat a balanced diet? Yes No Do you eat a lot of high sugar or fatty foods? Yes No  
• In the past 7 days, how many servings of fried or high fat foods did you typically eat each day?  
(Examples: fried chicken or fish, French fries, potato or corn chips, doughnuts, creamy salad dressings, foods made with whole milk, cream cheese, or mayo.) \_\_\_\_\_ servings per day  
• In the past 7 days how many sugar sweetened (not diet) beverages did you typically consume each day? \_\_\_\_\_ sugar sweetened beverages per day

Are you willing to commit to a change in your lifestyle habits to improve your health? \_\_\_\_\_

**Vaccinations:**

Do you get a yearly flu shot? Yes No  
Have you had a pneumonia shot? Yes No If yes, when? \_\_\_\_\_  
Have you had a shingles shot? Yes No If yes, when? \_\_\_\_\_  
Have you had a tetanus shot? Yes No If yes, when? \_\_\_\_\_

Please list the medications you are currently taking (both prescription and over the counter). Please bring your current medications to your appointment. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list the any other doctors or dentists you see, and why you see them: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any health concerns that we can address? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Attached to this form is a questionnaire we would like you to complete in addition to this health assessment form. Please bring these with you to your exam.*

# The Patient Health Questionnaire (PHQ-9)

## Patient Information

Name \_\_\_\_\_

DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**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 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

Colum Totals \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

Add Totals Together \_\_\_\_\_

10. If you check off any problems, 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 difficult at all       Somewhat difficult       Very difficult       Extremely difficult