HAMPDEN MEDICAL GROUP HEALTH ASSESSMENT FORM

Patient Information

Name _____ DOB: _____ Today's Date: _____

General Health (circle your response):

- During the past **4 weeks**, how would you rate your health?
  Excellent Very Good Good Fair Poor
- How have things been going for you during the past **4 weeks?**
  Very well Pretty Well Just okay Pretty Bad Very Bad
- In the past **4 weeks** how much pain have you felt? None Some A lot
- In the past **4 weeks** 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 **4 weeks**, 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 **4 weeks,** what was the hardest physical activity that you could do for at least two minutes?
  Very Heavy Heavy Moderate Light Very Light
- Can you get to places out of walking distance without help (can you travel alone in your car or by using public transport)? Yes No
- How often do you get the social and emotional support you need?
  Always Usually Sometimes Rarely Never
- How confident are you that you can control and manage most of your health problems?
  Very Confident Somewhat confident Not very confident I do not have health problems

Injury Risks (circle your response)

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	Are you afraid of falling?	Yes	No
Do you have difficulty keeping track of your medications?	Yes	No	Have you fallen two or more times in the past year?	Yes	No
Do you have difficulties driving a car?	Yes	No	Do you wear seatbelts ?	Yes	No

Social/Lifestyle Habits (circle your response)

Do you exercise? Yes No How often and what do you do? _____

Do you have trouble taking medications? Yes No _____

During the past **4 weeks** have you been bothered by the following problems?

Falling or dizziness upon standing	Yes	No	Sexual problems	Yes	No
Trouble eating well	Yes	No	Teeth or denture problems	Yes	No
Problems using the telephone	Yes	No	Tiredness or fatigue	Yes	No

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 any other doctors or dentists you see: _____

_____

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