

Your Full Name: _____ Date of Birth _____

Street Address: _____
Street City Zip Code

Phone Numbers: _____ Email: _____

Please check the box that answers the questions below and write any additional information that will help us meet your needs better. ***Please, No Blank Answers.***

1. What is your natural language? English Spanish Other: _____

2. A. Where do you currently live?
 Independent house, apartment, mobile home
 Assisted Living Apartment, or board & care Name: _____
 Nursing home Name: _____
B. Do you OWN or RENT? (please circle)

3. What is your current living arrangement? (check each that applies)
 Live Alone With other relative(s)
 With spouse/significant other With non-relative(s)
 With child(ren) With paid caregiver

4. A. Do you plan on changing your present living arrangements in the next 6 months?
 Yes No Describe _____
B. Do you feel safe in your neighborhood? Yes No _____

5. Have you seen your current (Primary Care Physician) PCP in the last 3 months? No
 Yes Who is it? _____

6. Are you under the care of any Specialist, if yes Name & Specialty? No
 Yes Names/Specialties _____

7. Have you been treated at the Emergency Room in the past 6 months? No
 Yes, number of times: _____ Why? _____

8. Have you been in a Skilled Nursing Facility in the past 12 months? No
 Yes, number of times: _____ Why? _____

9. Have you stayed overnight in a hospital in the past 12 months? No
 Yes, number of times: _____ Why?: _____

10. In general would you say your health is: (Check one answer)
 Excellent Very Good Good Fair Poor

11. Do you feel you have a problem with:
→ Alcohol Yes No OR → Drug Abuse Yes No
How often do you drink alcohol? _____

EXAMPLE 1-2 drinks, 3x a wk

12. Do you smoke or use tobacco products? Yes No Type _____
 12a. If YES, are you interested in a Smoking Cessation Program? Yes No
13. A. Are you a former smoker? Yes No Year Started _____ Year Quit _____
 B. Chew? Yes No C. Using ECig? Yes No
14. Have you had sex in the past 12 months? Yes No
 14a. Please circle: vaginal, oral, or anal
 14b. With: Men only Women Only Both Men and Women
 14c. Use Protection? Yes No TYPE OF PROTECTION _____
 14d. How many sexual partners have you had in your lifetime? _____
15. Have you ever had a Sexually Transmitted Disease? Yes No **If NO, go to #16**
Chlamydia Yes No *HPV* Yes No *HSV I* Yes No *HSV II* Yes No
Syphilis Yes No *GC* Yes No *Trichomoniasis* Yes No
 Other _____
16. A. Experience sexual abuse? No Past Now Do you feel safe now? Yes No
 B. Experience verbal abuse? No Past Now Do you feel safe now? Yes No
 C. Experience physical abuse? No Past Now Do you feel safe now? Yes No
17. Have you ever been treated for the following conditions? If yes, describe:
 Yes No Stroke _____
 Yes No Heart Attack _____
 Yes No Chest Pain _____
18. Do you have any wounds, sores or skin breakdown? No
 Yes Describe _____
19. For each of the activities, indicate whether: you are able to do this **without help** or **needs some help performing activity**:

	NEEDS SOME HELP	ABLE TO DO WITHOUT HELP
Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>
Getting in/out of bed or chairs	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>
Managing Money	<input type="checkbox"/>	<input type="checkbox"/>
Taking Medications	<input type="checkbox"/>	<input type="checkbox"/>
Preparing Meals	<input type="checkbox"/>	<input type="checkbox"/>
Shopping and Errands	<input type="checkbox"/>	<input type="checkbox"/>
Housekeeping Chores	<input type="checkbox"/>	<input type="checkbox"/>
Using the Telephone.....	<input type="checkbox"/>	<input type="checkbox"/>

20. If you receive help with any of the above activities, **who is the helper?** **NONE**
 _____ Yes No
 Name Relationship Phone Number **May we contact?**

21. Do you use any of the following special equipment **because of a disability or health problem? Circle all that apply:**

1. NONE 2. Grab Bars 3. Bedside Commode 4. Wheelchair 5. Ramps
6. Walker 7. Hospital Bed 8. Cane 9. Raised Toilet Seat 10. Hoyer Lift

22. CIRCLE if you currently use or receive any of the following? NONE
Feeding Tube Colostomy Care Oxygen Catheter CPAP Other_____

23. Are you CURRENTLY being treated for any of the following health conditions?
For any "YES" answer, please describe:

- Yes No Dialysis or Chronic Renal Failure _____
 Yes No Memory Loss _____
 Yes No Arthritis _____
 Yes No Urinary Problems _____
 Yes No Breathing Problems _____
 Yes No High Blood Pressure _____
 Yes No Cancer _____
 Yes No Circulation Problems _____
 Yes No Osteoporosis _____
 Yes No Stomach/Bowel Problems _____
 Yes No Recent Fracture (last 12 months) _____
 Yes No Parkinson's _____
 Yes No Ankle/Leg Swelling or Edema _____
 Yes No Uncorrected Hearing Loss _____
 Yes No Congestive Heart Failure
 Yes No If you have Congestive Heart Failure, have you been hospitalized
for it in the last 12 months?

Other (Describe)_____

24. Do you need help at home because of health problems Yes No
24a. Are you unable to get help? Yes No Not Applicable

25. How would you describe your ease to pay bills?
 Very Easy Easy Difficult Somewhat Difficult Nearly Impossible

26. Are you currently receiving any of the following services from an agency?
 Yes No Home Health Nurse Yes No Home Health Aide
 Yes No Social Worker Yes No Adult Day Care Center
 Yes No Physical, Occupational, Speech Therapy at Home
 Yes No Transportation Assistance

27. Do you currently have any pain? Yes No If NO, go to question #28

27a. Pain Severity Scale 1-10 (1 is less severe, 10 is most severe)

- 1 2 3 4 5 6 7 8 9 10

27b. Do you take over the counter or prescription medicine for pain? Yes No
If YES, name of medicine _____

27c. Does the pain medicine provide adequate relief of your pain?

- All the Time Most of the Time Some of the Time Never

If YES, describe pain _____

28. Have you fallen in the last 12 months? Yes No
 27a. If yes, how many times? _____ Injury? _____
 27b. If yes, did you go to the hospital? _____
29. Which of the following statements applies to your health? Check all that apply.
 I stay in bed all or most of the time because of physical limitations
 I stay in the house all or most of the time because of physical limitations
 Need help from another person in getting around inside or outside the house
 I do not need help or special aid, but have trouble getting around freely
 I'm not limited in any way
30. Do you have Diabetes? Yes No
 30a. If Yes, have you had a Diabetic Eye Exam done in the past year?
 Yes No/Don't know PLACE _____
 30b. Have you had a Glaucoma (Eye Pressure) Screen done in the past year?
 Yes No/Don't Know PLACE _____
31. A. How is your eyesight? (While wearing glasses or contacts, if applicable)
 Excellent Good Fair Poor Blind
 B. Please circle if you wear lenses for Reading or Driving or Never or Always
32. Do you get a flu shot every year? Yes No Where? _____ When? _____
33. Have you ever had a pneumonia shot? Yes No Don't Know When? _____
34. Have you ever had a Zostavax shot (shingles vaccine)? Yes No Don't Know
35. A. Are your parents alive/health condition? _____
 B. Do you have children? Yes No # _____ If yes, are they alive? _____
36. Have you felt depressed in the last 3 months? Yes No
 34a. If YES, are you currently being treated for depression? Yes No
 34b. Do you want to discuss treatment options on your next appointment? Yes No
37. Have you completed an **Advance Directive**? Yes No
 (A document that **directs your health care wishes** in the event you become ill)
 36a. If YES, is it on file with your PCP? Yes No
 36b. If NO, are you interested in receiving information? Yes No
 36c. Who is responsible to carry out your wishes & relationship? _____
 36d. Circle Answer(s): Comfort Measures, DNR, Organ Donor, Resuscitate or NA

Thank you for completing these forms so that we can provide excellent care!

Magnolia Family Medicine Phone: 910-796-3212 Fax: 910-796-3216

3720 Shipyard Blvd. Wilmington, NC 28403

WWW.MAGNOLIAFMED.COM