FAMILY MEDICAL CENTER

Dr Jyotin K Patel MD Inc.,

ANNUAL Health Assesment

NAME OF PATIENT: _____ D. O. B. _____

Patient Instructions: Please answer the questions checking:

1	In general how would you rate your health	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor	
2	Do you currently take a daily Aspirin	☐ Yes ☐ No	
3	Have you had a flu Vaccine?	☐ Yes ☐ No ☐ Declined	If Yes Month/Year _____
4	Have you had a Pneumonia Vaccine?	☐ Yes ☐ No ☐ Declined	If Yes Month/Year _____
5	If you are between 50-75 yrs old, have had a screening for COLORACTAL CANCER in last 10 years?	☐ Yes ☐ No	If Yes ☐ FOBT ☐ Flexible sigmoidoscopy ☐ Colonoscopy ☐ Date: _____
6	Have you had a retinal eye exam by eye care professional last 2 years?	☐ Yes ☐ No	Date By ☐ Ophthalmology ☐ Optometrist
7	If you are a female between 50-74 years old have you had a mammogram in the last year?	☐ Yes ☐ No	Mammogram Results ☐ Normal ☐ Abnormal
8	Are you currently a SMOKER or you use any tobacco products	☐ Yes ☐ No	☐ Counseled on tobacco cessation ☐ Patient declined intervention
9	Do you have an ADVANCED DIRECSTIVE, LIVING WILL OR POLST?	☐ Yes ☐ No	☐ Advanced plan reviewed ☐ Patient deffered ☐ Other
10	In past 12 months have you had any problems with Balance, walking, or had Falls?	☐ Yes ☐ No	☐ Fall prevention counseling ☐ Referred to physical therapy ☐ Referred to vision/hearing eval ☐ High risk medication review
11	Any anexiety or stress a problem for you in handling your Health, Finances, Family, work or social Realtionships?	☐ Yes ☐ No ☐ Other	☐ Monitoring and counseling ☐ Social Services
12	Over past 2 weeks how often have you been bothered by following problems. **Little Interest** **Feeling down, depressed or hopeless?**	0 Not at all 1 Occasionally **2 frequently** **3 Daily**	☐ Yes ☐ No ☐ Rx given for antidepressant
13	For chronic pain patient: During last 4 weeks to what degree have you felt body pain? 0-1 2 3 4 5 6 7 8 9 10 none to severe		☐ Monitor and counseling ☐ Referred to pain mamagement ☐ Prescribed med,, ☐ Other
14	In the past six months have had problems with Urinary Incontinence	☐ Yes ☐ No	☐ Rx for incontinence ☐ Referred to Urology

Patient Signature: _____ Date: _____