Dr Lakin's Pre-Physical/Wellness Visit Forms

PLEASE PRINT!

Date: ________________

Name: ______________________________________ **Date of Birth:** ________________

Please complete before seeing Dr Lakin today.

Social History:

Current Tobacco use:	YES	NO	How much? ________________________
Current Alcohol use:	YES	NO	How much? ________________________

Allergies: ____

Are you having a problem with:

Abdomen/Stomach	YES	NO	Bladder/Urinary	YES	NO
Breathing/Lungs	YES	NO	Heart/Vascular	YES	NO
Nerves/ Unusual Sensations	YES	NO			

Other Concerns To Discuss Today: ____

Do you wish to discuss Advanced Care Planning (end of life planning) with Dr Lakin today?	YES	NO

Names of Specialists you see:

Cardiology:	Dermatology:
Gastroenterology:	Gynecology:
Oncology:	Ophthalmology:
Pulmonology:	Surgeon:
Urology:	Other:

Family Medical History:

Father:	Mother:
Brother:	Sister:

Signature: ____

Desmond Fall Risk Questionnaire

Paradise Valley Medical Clinic

Please answer all questions

Name ______________________ Date __________

Check the box if any of these apply to you

1. ☐ Have you had a fall or near fall in the past year?
2. ☐ Do you have a fear of falling that restricts your activity?
3. ☐ Do you experience dizziness or a sensation of spinning when you lie down, tilt your head back, or roll over in bed?
4. ☐ Do you feel uneasy or unsteady when walking down an aisle of a supermarket or in an area congested with other people?
5. ☐ Do you have difficulty walking in the dark, or on uneven surfaces such as gravel or a sloped sidewalk?
6. ☐ Do your feet or toes frequently feel unusually hot or cold, numb, or tingly?
7. ☐ Do you wear bifocal or trifocal glasses, or is your vision notably better in one eye?
8. ☐ Do you experience loss of balance, or a lightheaded/faint feeling when you stand up?
9. ☐ Do you take medication for depression, anxiety, nerves, sleep or pain?
10. ☐ Do you take four or more prescription medications daily?
11. ☐ Do you feel like your feet just won't go where you want them to go?
12. ☐ Do you feel like you can't walk a straight line, or are pulled to the side while walking?
13. ☐ Has it been longer than six months since you participated in a regular exercise program?
14. ☐ Do you feel that no one really understands how much dizziness and balance problems affect your quality of life?
15. ☐ Are you interested in improving your balance and mobility?

Paradise Valley Medical Clinic

Patient Name: ______________________ **Date:** ____________

Katz Index of Independence in Activities of Daily Living

Activities Points (1 or 0)	**Independence** (1 Point) **NO** supervision, direction or personal assistance.	**Dependence** (0 Points) **WITH** supervision, direction, personal assistance or total care.
BATHING Points: ________	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing
DRESSING Points: ________	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points: ________	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: ________	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: ________	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points: ________	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS: ______ **SCORING:** 6 = High (*patient independent*) 0 = Low (*patient very dependent*

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:____________

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 or 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 are 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 figety 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	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: 0

10. If you checked off *any problems*, how *difficult* have these 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

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