

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 YES NO
(end of life planning) with
Dr Lakin today?

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)	Dependence (0 Points)
	NO supervision, direction or personal assistance.	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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Feeling down, depressed, or hopeless	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Feeling tired or having little energy	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Poor appetite or overeating	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
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 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

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	<input type="checkbox"/>
	Somewhat difficult	<input type="checkbox"/>
	Very difficult	<input type="checkbox"/>
	Extremely difficult	<input type="checkbox"/>