RANDALL MAXEY, MD, PhD

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NAME: ________________________________ DATE:: ____________________

I. PATIENT HEALTH QUESTIONNAIRE (PHQ-2)

Over the last 2 weeks, how often have you been bothered by Any of the following problems?	NOT AT ALL(0)	SEVERAL DAYS(+1)	MORE THAN HALF THE DAYS(+2)	NEARLY EVERY DAY(+3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				

ADD ALL THE COLUMNS _______ + __________ + ________

TOTAL SCORE ______

II. MOOD ASSESSMENT

In the past 2 weeks, how did you feel about your: (circle one face each line)

SLEEP	😀	😊	😐	🙁	😞	😢
FAMILY AND FRIENDS	😀	😊	😐	🙁	😞	😢
STRESS	😀	😊	😐	🙁	😞	😢
INSPIRATION	😀	😊	😐	🙁	😞	😢
PHYSICAL ACTIVITY	😀	😊	😐	🙁	😞	😢

III. INCONTINENCE ASSESSMENT

	YES	NO
In the past 12 months, have you had a problem with bowel (fecal) or bladder (urine) incontinence that is bothersome enough that you would like to know more about how it could be treated		

IV. PAIN ASSESSMENT

DO YOU HAVE PAIN?	☐ **YES** ☐ **NO**	IF YES, WHERE?

INTENSITY (CIRCLE ONE)	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
HOW LONG HAVE YOU HAD THIS PAIN?											
WHAT DO YOU TAKE TO HELP?											

V. PHYSICAL ASSESSMENT

How often do you exercise per week?	☐ **≥ 5 days**	☐ **4-3 days**	☐ **2-1 day**	☐ **Seldom**	☐**Never**

VI. CURRENT MEDICATIONS (PRESCRIPTION, OVER-THE-COUNTER AND HERBAL MEDICATIONS)

#	NAME OF MEDICATION	DOSE	DIRECTIONS	WHEN DO YOU TAKE IT
1				
2				
3				
4				
5				

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VII. FRAIL ASSESSMENT

Question	Response	
How much of the time during the past 4 weeks did you feel tired? (fatigue) (Circle one)	ALL OF THE TIME / MOST OF THE TIME / SOME OF THE TIME / A LITTLE OF THE TIME / NONE OF THE TIME Response is either "all of the time" or "most of the time"= 1	
By yourself and not using aids, do you have any difficulty walking up 10 steps without resting?	▢ **YES (1)** ▢**NO (O)**	
By yourself and not using aids, do you have any difficulty walking several hundred yards?	▢ **YES (1)** ▢**NO (O)**	
Did a doctor ever told you that you have: **(circle all that apply)**	Hypertension Cancer Chronic Lung Disease CHF Diabetes Heart Attack Angina Asthma Arthritis Stroke If total number of illnesses is 5 or more= 1	
How much do you weigh with your clothes on but without shoes? One year ago, how much did you weigh?	____________**lbs.** ____________**lbs.** **5% or more weight loss= 1**	

MEDICAL ASSISTANT TO ADD THE TOTAL SCORE:________

VIII. FUNCTIONAL ASSESSMENT

ACTIVITIES	**INDEPENDENT (1 POINT each)** **NO** supervision, direction or personal assistance	**DEPENDENT (0 POINT each)** **WITH** supervision, direction, personal assistance or total care
BATHING	Bathes self completely or needs help in bathing only a single past of the body ▢	Needs help in bathing more than one part of the body, getting out of the tub or shower ▢
DRESSING	Gets clothes from closets and drawers and puts on clothes and other garments complete with fasteners. May have helped tying shoes. ▢	Needs help with dressing self or needs to be completely dressed. ▢
TOILETING	Goes to the toilet; gets on and off, arranges clothes, cleans gential area without help ▢	Needs help transferring to the toilet, cleaning self or uses bedpan or commode ▢
TRANSFERRING	Moves in and out of bed or chair unassisted . Mechanical transferring aides are acceptable ▢	Needs help in moving from bed to chair or requires a complete transfer ▢
CONTINENCE	Exercises complete self-control over urination and defecation ▢	Is partially or totally incontinent of bowel or bladder ▢
FEEDING	Gets food from plate to mouth without help. Preparation of food may be done by another person. ▢	Needs partial or total help with feeding or requires parenteral feeding. ▢

MEDICAL ASSISTANT TO ADD THE TOTAL SCORE: __________

VX. HISTORY

ALCOHOL/TOBACCO DRUGS RISK SCREEN	Have you ever smoked cigarettes, a pipe or cigars or chewed tobacco? ▢**Yes** ▢ **No** If Yes, how much and for how long? ____________________ Do you ever drink alcohol? ▢**Yes** ▢**No** If Yes, how much? ____________________ Have you ever used any street drugs or taken prescription medications that were not prescribed for you? ▢ **Yes** ▢ **No** If Yes, what drugs/meds? ____________________ For how long? ____________
PERSONAL HISTORY	Marital Status: ▢**Married** ▢ **Single** ▢**Divorced** Do you have an Advance Directive? ▢**Yes** ▢**No**
PAST SURGICAL HISTORY What and When?	