Health and Social Assessment

Name: _____ DOB: _____

What language do you prefer us to communicate with you? (Please circle one)

English Spanish Other: _____

Will you need the assistance of an interpreter? Yes ☐ No ☐

Do you have a(n):

	Yes	No	Copy Provided
Living Will			
Advanced Directive			
DNR (Do Not Resusitate)			
Durable Power of Attorney			

Who would speak for you if you are unable to make health decisions?

Name: _____ Relationship: _____

Phone Number: _____

Medical History

Have you or any immediate members of your family been diagnosed with any of the following? (Check all that apply)

	Yourself	Mother	Father	Brother(s) Sister(s)	Grand-parents
Anxiety/Depression					
Bipolar Disorder					
Cancer (any form)					
Dementia/Alzheimer's					
Diabetes					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Insomnia					
Schizophrenia					
Sleep Apnea					
Stroke					
Thyroid Disease					

My mother is: Living/ Deceased Age at death: _____ Cause of death: _____

My Father is: Living/ Deceased Age at death: _____ Cause of death: _____

Surgical History

	Yes	No	Year		Yes	No	Year
Appendectomy				Hysterectomy			
Cataract Extraction				Knee Replacement			
Gallbladder				Masectomy			
Heart Bypass				Pacemaker Placement			
Heart Stent Placement				Tonsilectomy			
Heart Valve Replacement				Tubal Ligation			
Hernia Repair				Other:			
Hip Repair/Replacement				Other:			

Previous Medical Testing

Have you had any of the following tests?

Eye examination Declined ☐ No ☐ Yes ☐ Date: _____

Hearing Evaluation Declined ☐ No ☐ Yes ☐ Date: _____

Colonoscopy Declined ☐ No ☐ Yes ☐ Date: _____

Bone Density (DEXA) Declined ☐ No ☐ Yes ☐ Date: _____

CPAP/BiPAP use No ☐ Yes ☐

FOR MEN ONLY:

Prostate Exam Declined ☐ No ☐ Yes ☐ Date: _____

PSA blood test Declined ☐ No ☐ Yes ☐ Date: _____

FOR WOMEN ONLY:

Mammogram Declined ☐ No ☐ Yes ☐ Date: _____

Pap Smear Declined ☐ No ☐ Yes ☐ Date: _____

In the last 5 years have you been hospitalized for any reason? No ☐ If yes, please list.

Year	Hospital	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Immunizations

Influenza vaccine Declined ☐ Not received ☐ Yes ☐ Year:_____

Pneumonia vaccine Declined ☐ Not received ☐ Yes ☐ Year:_____

Tetanus/Pertussis vaccine Declined ☐ Not received ☐ Yes ☐ Year:_____

Zoster (shingles) vaccine Declined ☐ Not received ☐ Yes ☐ Year:_____

Did you have any type of reaction with these immunizations? Yes ☐ No ☐

Economic

What is your highest level of education? _____

What do/did you do for a living? _____

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Do you have difficulty paying for your medications? Yes ☐ No ☐

Do you take less medication than prescribed to save costs? Yes ☐ No ☐

*Would you like to receive assistance in paying for your medications? Yes ☐ No ☐

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**Do you need assistance with Transportation? Yes ☐ No ☐*

Social

What is your current marital status?

Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed ☐

Do you have any children (living and deceased)? Yes ☐ No ☐

Is your current living situation permanent? Yes ☐ No ☐

Who are you currently living with?

Alone ☐ Spouse ☐ Family ☐ Friends ☐ Other ☐

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Have you ever smoked cigarettes or used tobacco products? Yes ☐ No ☐

How much do/did you smoke per day? ½ pack or less ☐ 1 pack ☐ 1-2 packs ☐

How many years did you smoke/use? _____ What year did you quit? _____

*Would you be interested in participating in smoking cessation program? Yes ☐ No ☐

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Do you consume any caffeine? Yes ☐ No ☐

Coffee ☐ Tea ☐ Soda ☐ Energy drinks ☐ Chocolate ☐

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Do you drink alcohol? Yes ☐ No ☐

Daily ☐ Weekly ☐ Rarely ☐ Socially ☐ Occasionally ☐

*Would you be interested in assistance to stop drinking? Yes ☐ No ☐

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Mobility/Physical Health

Have you fallen in the past year? Yes ☐ No ☐

If yes, please briefly describe the circumstances surrounding your fall:

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____

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Do you use a walking aid? No ☐ If yes, please check below:

Cane ☐ Wheelchair ☐ Walker ☐

**Would you like to receive education on falls and balance? Yes ☐ No ☐*

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What do you do to stay physically active?

Walking ☐ Golf ☐ Cycling ☐ Swimming ☐ Tennis ☐ Yoga ☐

Other: ____

Daily ☐ 2-3 times per week ☐ 4-5 times per week ☐ occasionally ☐

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What is your preferred pharmacy? ____

Do you have any allergies to medications? ______________________________________

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Please list any other physicians that you are currently seeing:

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