SOUTH COAST MEDICAL GROUP
FAMILY PRACTICE & URGENT CARE
WWW.SOUTHCOASTMEDGROUP.COM
(949)-360-1069

Senior Patient
Annual Preventive Screening Questionnaire

Patient Name: _____ **Date of Birth**:_____

Date of Annual Wellness Visit today: _____

Bring this completed form to review with your doctor at your **Annual Preventive Visit**. Some items may not apply to you. This visit is **NOT** a problem visit; it is strictly for annual screening. ***Do not use this visit for a problem visit. (A physical exam is NOT included in this visit)***

Patient Questionnaire Section : ***(please fill out before your visit)***

Do you have an Advanced Directive? *Yes* / No **Do you have a Durable Power of Attorney?** Yes / No
(**CPT II - 1158F)*

(Name/Number of Power of Attorney) _____

How do you rate your health in general? Poor Fair Good Very good Excellent

Do you walk/exercise 3 or more times a week? Yes / No **Urine: Any leakage?** *Yes* / No **CPT II - 1090F*

Do you have to strain to hear/understand conversations? *Yes* / No
Balance: Any falls in the past 6 months? Yes / No **Any trouble walking or standing?** *Yes* / No
**CPT || - 0518F*
Chronic Daily Pain: rate the level of your pain: (No Pain) 0 1 2 3 4 5 (Severe)
(*none *1126F) (*chronic or daily pain present CPT II - 1125F)*

Compared to a few years ago, do you have MORE trouble:
Remembering things that happened recently? *Yes* / No
Recalling conversations after a couple of days? Yes / No
Trouble paying bills/managing money? *Yes* / No
**CPT II – 3755F*

Social & emotional: Do you have support from friends or family? *Yes* /No

(Please circle all that apply) **Do you need help: eating bathing dressing or toileting shopping, and/or cooking**

Nutrition: Did you lose or gain more than 5 lbs. in the last month? Yes / No

Habits: *(please check if you ...)* **O** Smoke : (#) ____/day for (#) ___years *(*1000F)*
O Drink Alcohol: (#) ___per day / week / month

Does your Home have: *(check all that apply)*
O Smoke detector working **O** Carbon Monoxide detector working **O** Firearms (Guns) **O** Throw rugs
O Non-slip bath mat **O** Stairs **O** Handrails
******** CPT II: For physician use only***

Safety: Do you drive? *Yes* / No **Wear seatbelts in the car?** Yes / No

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Initial AWV G0438 /Subsequent AWV G0439

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)
Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	**Several days**	**More than half the days**	**Nearly everyday**
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
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**	**1**	**2**	**3**
Thoughts that you would be better off dead or of hurting yourself	**0**	**1**	**2**	**3**
(Office use only)Totals				
(Office use only)Total score				

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? (please circle)			
Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely Difficult**

CPT II 3725F

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