

SOCIAL HISTORY

Smoking Status

Current ____/Day for ____yrs
 Former ____/Day for ____yrs
 Never

Marital Status Occupation

Married _____
 Single _____
 Widowed _____
 Divorced _____
 Other _____

Children

Yes No How Many? ____

Alcohol Use

Yes No How much? _____

Caffeine Use

Yes No Type? _____

Illicit Drug Use

Yes No Type? _____

Able to Care for Self?

Yes No

Financial Concerns?

Yes No

Support at Home?

Yes No

Transportation Concerns?

Yes No

I Live in a _____

I Live with _____

ADVANCED DIRECTIVES

Do you have an advanced directive? Y N

Do not resuscitate?

Do you have a living will? Y N

Do you have a power of attorney? Y N

FALL RISK ASSESSMENT

Do you have a history of falling? Y N

Do you use:

Crutches Cane Walker Wheelchair
 Special furniture Other _____

Do you have a PICC line? Y N

NUTRITION SCREEN

Decreased food intake over past 3 months?
 Unintentional weight loss over last 3 months?

Are you:

Home bound, and bed or chair bound?
 Home bound, but not bed/chair bound?
 Not home/bed/chair bound?

Have you suffered psychological stress or acute disease in the past 3 months? Y N

Neuropsychological problems? Y N

What is your height ____? Weight ____?

FAMILY HISTORY

(Please Check)

	Mother	Maternal GPs	Father	Paternal GPs	Sibling	Child	No History	Other
Unknown History								
Cancer								
Diabetes								
Heart Disease								
Hypertension								
Kidney Disease								
Lung Disease								
Mental Illness								
Stroke								
Thyroid Problems								
Tuberculosis								
Seizures								
Other								

MEDICATION/SUPPLEMENT LIST

Medication/Supplement Dose & Frequency

NUTRITION ASSESSMENT

Do you: (Check all that apply)

Live independently (not in a nursing home or hospital)?

Take more than 3 prescription drugs per day?

Pressure sores or skin ulcers?

How many full meals do you eat daily? ____

Do you eat (Check all that apply):

At least one serving of dairy products (milk, cheese, yogurt) a day.

Two or more servings of legumes or eggs per week

Meat, fish or poultry every day

Eat two or more servings of fruits or vegetables per day?

How much fluid (water, juice, coffee, milk) to you drink per day? ____

Do you need help when eating? Y N

Do you feel your nutritional status is:

Poor Unknown Good

Do you feel your health status for your age is:

Worse than average Unknown

Average Better than average

Other:

Highest education level?

Religious Preference