Name: _____ **Date:** _____

DOB: _____

Review of Systems: Please checkmark any symptoms you are currently experiencing.

General
___ chills
___ daytime sleepiness
___ fatigue
___ fever
___ loss of appetite
___ malaise
___ night sweats
___ severe snoring
___ trouble sleeping
___ unexpected weight loss

Eyes
___ blurred vision
___ discharge
___ double vision
___ eye irritation
___ eye pain
___ light sensitivity
___ loss of vision

Ears, Nose, & Throat
___ decreased hearing
___ difficulty swallowing
___ ear discharge
___ earache
___ face or jaw pain
___ hoarseness
___ nasal congestion
___ nosebleeds
___ nasal discharge
___ ringing in the ears
___ sore throat

Cardiovascular
___ chest pain or discomfort
___ calf pain with walking
___ difficulty breathing at night
___ difficulty breathing laying down
___ fainting or near fainting
___ leg cramps
___ lightheadedness
___ discomfort breathing relieved by sitting or standing
___ palpitations or racing heart
___ hard time breathing when lying down
___ peripheral edema
___ recent weight gain
___ shortness of breath with exertion
___ swelling in extremities
___ syncope

Breast
___ abnormal mammogram
___ bloody discharge from nipple
___ breast enlargement
___ breast pain
___ breast lump
___ nipple discharge

Respiratory
___ chest pain with deep breaths
___ cough
___ coughing up blood
___ excessive mucus or phlegm
___ excessing snoring
___ excessive sputum
___ hemoptysis
___ pleuritic chest pain
___ shortness of breath
___ wheezing

Gastrointestinal
___ abdominal bloating
___ abdominal pain
___ bloody stools
___ change in bowel movements
___ constipation
___ black tarry stools
___ diarrhea
___ trouble swallowing
___ heartburn
___ hemorrhoids
___ indigestion
___ nausea
___ pain with swallowing
___ vomiting
___ vomiting blood
___ yellowish skin color

Genitourinary - Men
___ blood in urine
___ decreased libido
___ discharge
___ pain with urination
___ erectile dysfunction
___ genital sores
___ nighttime urination
___ trouble starting urination
___ urinary frequency
___ urinary hesitancy
___ urinary urgency
___ urinary incontinence

Musculoskeletal
___ neck pain
___ thoracic pain
___ lumbar pain
___ general weakness
___ joint pain
___ joint swelling
___ muscle aches
___ muscle cramps
___ muscle weakness
___ stiffness

Skin
___ change in hair or nails
___ dry skin
___ excessive perspiration
___ itching
___ non-healing sores
___ rash
___ skin cancer
___ suspicious lesions
___ unusual hair distribution

Neurologic
___ arm or leg weakness
___ confusion
___ dizziness or sensation of spinning
___ facial weakness
___ falling down
___ headaches
___ loss of consciousness
___ numbness or tingling
___ poor balance or coordination
___ poor memory
___ seizures or uncontrolled movements
___ slurred speech
___ tremors
___ trouble concentrating
___ visual disturbances

Mental Health
___ depressed mood
___ anxious mood
___ fears or phobias
___ frightening visions or sounds
___ thoughts of suicide
___ thoughts of violence to others

Endocrine
___ intolerance to cold
___ intolerance to heat
___ excessive hunger
___ excessive thirst
___ excessive urination

Blood
___ enlarged glands
___ excessive or easy bruising
___ prolonged bleeding

Allergy
___ hives or rash
___ persistent infections
___ possible HIV exposure
___ seasonal allergies

Other:
_____

_____

Medicare Exam Screening Questionnaire

Depression Screen:

Over the past two weeks have you felt down, depressed, or hopeless? **[ ]** Yes **[ ]** No

Over the past two weeks, have you felt little interest or pleasure in doing things? **[ ]** Yes **[ ]** No

Fall Prevention:

Do you have a history of falling within the prior 12 months? **[ ]** Yes **[ ]** No

Do you require an ambulatory aid when walking? **[ ]** Yes **[ ]** No

Do you experience low blood pressure (hypotension)? **[ ]** Yes **[ ]** No

Do you have gait/balance problems or lower extremity weakness? **[ ]** Yes **[ ]** No

Do you have risk factors at home (e.g., loose rugs, inadequate grab rails, poor lighting)? **[ ]** Yes **[ ]** No

Hearing Screen:

Do you have trouble hearing the television or radio when other do not? **[ ]** Yes **[ ]** No

Hearing device: **[ ]** Yes **[ ]** No

Do you strain or struggle to hear/ understand conversations? **[ ]** Yes **[ ]** No

Functional Ability/Screening:

Do you need help with any of these daily activities? (Circle **all that apply**) Telephone, transportation, shopping, meals, housework, laundry, medications or managing money? **[ ]** Yes **[ ]** No

Nutrition Screening:

Have you had any unintentional weight loss? **[ ]** Yes **[ ]** No

Do you have a problem with appetite, chewing or swallowing? **[ ]** Yes **[ ]** No

Do you have trouble getting food because of limited finances, mobility, or mental status? **[ ]** Yes **[ ]** No

Have you had a prolonged hospitalization, major surgery or serious infection? **[ ]** Yes **[ ]** No

Do your medical problems or medications affect nutrition? **[ ]** Yes **[ ]** No

Physical Health:

Do you have regular exercise program? **[ ]** Yes **[ ]** No

Would you like to discuss participation in a physical fitness program? **[ ]** Yes **[ ]** No

Bladder Control:

Do you have trouble with urinary leakage? **[ ]** Yes **[ ]** No

Would you like to discuss treatment options? **[ ]** Yes **[ ]** No

Nine Symptom Checklist

Please answer **EVERY** question with only **ONE** choice.

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 every day**
	0	**1**	**2**	**3**
a. Little interest or pleasure in doing things.				
b. Feeling down, depressed, or hopeless.				
c. Trouble falling/staying asleep, sleeping too much.				
d. Feeling tired or having little energy.				
e. Poor appetite or overeating.				
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
g. Trouble concentrating on things, such as reading the newspaper or watching television.				
h. 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.				
i. Thoughts that you would be better off dead or of hurting yourself in some way.				

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?

[ ] Not difficult at all
[ ] Somewhat difficult
[ ] Very difficult
[ ] Extremely difficult