Yearly Physical Questionnaire

Date: _____

Name: _____ **Birthday:** _____

Do you need assistance from a walker/cane/wheelchair? **YES NO**
In the past 12 months have you had any problems with balance or unsteadiness? **YES NO**
In the past 12 months have you had a fall? **YES NO**
If yes, were you injured from this fall? **YES NO**
Does your home have any trip hazards such as throw rugs or uneven floors? **YES NO**

Do you live **Alone Spouse Family Caregiver**
Type of residence **Home Apartment Assisted Living Nursing Home**
# of stories **1 2**
Does the home have smoke detectors? **YES NO**
Is there any Durable Medical Equipment being used in the home? **YES NO**
Are you financially able to pay for your medications every month? **YES NO**
Form of transportation **Drives self Family Public transportation**

Type of Diet **Regular Low Fat Diabetic Low Sodium Low Cholesterol**

Current smoker **YES NO** Former smoker **YES NO**
Do you drink alcohol? **YES NO**
If yes, how many drinks do you consume per week? _____
Have you seen a dentist in the last 12 months? **YES NO**
Are you sexually active? **YES NO**

How is your health today compared to last year? **Same Better Worse**
Do you have concerns about your vision? **YES NO**
Do you wear glasses? **YES NO**
Do you have concerns about your hearing? **YES NO**
Do you wear hearing aids? **YES NO**
Do you have concerns about your memory? **YES NO**
In the last 2 weeks have you experienced feelings of depression? **YES NO**

How often do you experience bladder leakage? **Not at all Sometimes All the time**

Do you need assistance with bathing or grooming? **YES NO**
Do you need assistance with toileting? **YES NO**
Do you need assistance with eating? **YES NO**

Do you have an Advanced Directive? **YES NO**

Do you see any Specialists? **YES NO**
If yes, please list them below.

Name:_____ **Birthday:** _____

Have you had and of the following:

Recent weight changes	**YES**	**NO**
Fatigue in the last 6 months	**YES**	**NO**
Chronic cough	**YES**	**NO**
Shortness of breath	**YES**	**NO**
Chest pain	**YES**	**NO**
Palpitation	**YES**	**NO**
Painful or swollen joints	**YES**	**NO**
Difficulty walking	**YES**	**NO**
Chronic headaches	**YES**	**NO**
Any loss in height	**YES**	**NO**
Excessive thirst	**YES**	**NO**
Changes in hearing	**YES**	**NO**
Frequent nose bleeds	**YES**	**NO**
Nausea / Vomiting	**YES**	**NO**
Changes in bowel habits	**YES**	**NO**
Blood in urine	**YES**	**NO**
Hair loss	**YES**	**NO**
Skin Rashes / Itching	**YES**	**NO**

Women Only:

Abnormal vaginal discharge	**YES**	**NO**
Abnormal vaginal bleeding	**YES**	**NO**
Abnormal lumps in breast	**YES**	**NO**

Men Only:

Discharge from penis	**YES**	**NO**
Lump on testicles	**YES**	**NO**