

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