1. Please write down questions and issues you want to discuss today with the doctor

__________________________________________________________________________

2. Have there been any new changes in thinking abilities or functioning?

__________________________________________________________________________

3. Have there been any new changes in behavior/mood? (For example: depression, anxiety, irritability, anger, hallucinations, paranoia, etc.)

__________________________________________________________________________

4. List changes or any new prescription medications. Are any refills needed?
   
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage</th>
<th>Times per day</th>
<th>Is this Med new or changed?</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

5. List changes or any new over-the-counter medications or supplements.

__________________________________________________________________________

6. List new medication allergies, medical conditions, hospitalizations or surgeries since your last visit.

__________________________________________________________________________

**HEALTH HABITS**

7. Have you been smoking? Yes _____ No _____

8. Do you drink wine, beer or liquor? Yes _____ No _____

9. Have you used other drugs / substances? Yes _____ No _____

10. Do you exercise regularly? Yes _____ No _____

11. Have you fallen in the last year? Yes _____ No _____
12. List current hobbies or outside activities:

______________________________________________________________________________

**DAILY FUNCTIONING**

Are you driving? Yes _____ No _____

<table>
<thead>
<tr>
<th>TASK</th>
<th>Independent</th>
<th>Needs Some Assist or Cueing</th>
<th>Needs Much Assistance</th>
<th>Unable to Do</th>
<th>Never did this task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking public transportation</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
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<tr>
<td>Housekeeping</td>
<td></td>
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<tr>
<td>Meal preparation</td>
<td></td>
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</tr>
<tr>
<td>Handling finances</td>
<td></td>
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</tr>
<tr>
<td>(banking, investing, budgeting)</td>
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<tr>
<td>Managing money</td>
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</tr>
<tr>
<td>(making change, paying bills)</td>
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<tr>
<td>Taking Meds</td>
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<tr>
<td>Using the telephone</td>
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<tr>
<td>Doing laundry</td>
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<tr>
<td>Socializing</td>
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<tr>
<td>Getting dressed</td>
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<tr>
<td>Bathing or showering</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Grooming (teeth, hair, shaving)</td>
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<tr>
<td>Toilet hygiene</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Feeding self</td>
<td></td>
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</tbody>
</table>

Would you or a partner / family member like to meet with a social worker?

Yes _____ No _____ Unsure _____

If yes or unsure, list any concerns that you might want to discuss with a social worker: ____________

______________________________________________________________________________

______________________________________________________________________________
REVIEW OF SYSTEMS

Rate your overall health: very good  good  fair  poor

Please circle any NEW problems you are having since your last visit or check None: ☐

**General:**
- Weight change: Inc / Dec
- Fatigue / malaise
- Fever / Chills

**Pain**
- Local: (where): __________
- Generalized

**Skin:**
- Rash / itching
- Other: _______________

**Eyes:**
- Wear glasses / contacts
- Double vision
- Blurred vision
- Visual loss
- Dry eyes
- Cataracts
- Glaucoma

**Ears:**
- Hearing loss
- Ringing in ears
- Dizziness (Vertigo)

**Nose, Mouth and Throat:**
- Hoarseness
- Dry mouth
- Loss of sense of smell
- Loss of sense of taste

**Heart:**
- Chest pain
- Fainting
- Low blood pressure
- High blood pressure
- Slow heart rate
- Fast heart rate
- Irregular heart beat
- Cold feet / hands
- Leg swelling

**Lungs**
- Shortness of breath
- Chronic cough

**Gastrointestinal:**
- Change in appetite
- Difficulty swallowing
- Stomach pains / heartburn
- Nausea/vomiting
- Diarrhea
- Constipation
- Liver disease
- Bowel incontinence

**Metabolic:**
- Excess thirst
- Heat / cold intolerance
- Change in sexual interest: increased / decreased
- Hair loss
- Thyroid problems
- High cholesterol / lipids

**Genital-urinary:**
- Difficulty urinating
- Nighttime urination
- Urinary urgency
- Urinary incontinence / leakage
- Urinary tract infection (recent)
- Sexually active: Y/ N/ No Ans
- Erectile dysfunction

**Hematologic**
- Anemia
- Swollen lymph nodes

**Musculoskeletal:**
- Muscle pain
- Joint pain
- Back pain
- Fibromyalgia / Chronic fatigue
- Nighttime muscle cramps

**Neurological:**
- Head injury + loss of consciousness
- Headaches
- Seizures
- Muscle weakness ________
- Numbness / tingling ________
- Loss of balance
- Falls
- Slow movements
- Tremor
- Learning disability or ADHD

**Problems with sleep**
- Insomnia
- Tired in the morning
- Falling asleep during day
- Bedtime: ______
- Wake time: ______
- Snoring
- Stop breathing
- Moving during sleep

**Psychiatric:**
- Anxiety (nervousness)
- Depression (sadness)
- Previous psychiatric hospitalization: Y / N
- Hallucinations
- Delusions (e.g., paranoia)
- Compulsive behavior
- History of suicide attempt: Y / N

**Other:** _______________
- _______________
- _______________
- _______________
- _______________
- _______________