COMPREHENSIVE EVALUATION INSTRUMENT

To enable us to provide you with the best possible care, please complete the following:

Date: ______________________

Name ______________________ Social Security # ______________________
First Full Middle Last

Address______________________ City ______________ Zip Code_____________

Telephone (home) ______________________ (work) ______________________

Date of Birth ______________________ Gender: Circle M F

Marital status ☐ Married (name of spouse) ____________ ☐ Widowed ☐ Single ☐ Divorced

Race/ethnicity ☐ White ☐ Black ☐ Hispanic ☐ Asian/Pacific Islander ☐ Other____________

For emergency notify: ______________________ Relation______________

Address ______________________City______________State_____Zip Code__________

Phone (home)______________________ (work) ______________________

E-mail address: ______________________

Is there a friend, relative, or neighbor who would take care of you for a few days if necessary? ☐ Yes ☐ No

Please list any doctors you are currently seeing (i.e., primary care, cardiologist, dermatologist, etc.)

Doctor's Name Address Phone Number

____

____

____

Health Maintenance

Please provide the dates of the most recent services in the table below:

	Month/Year
Sigmoidoscopy or colonoscopy	
Mammogram	
PAP smear	
Bone mineral density (osteoporosis screen)	
Influenza vaccination (Flu shot)	
Pneumovax	
Tetanus	
Cholesterol screening	
Vision screen/Hearing screen	/

Patient Name______________________

APN/MD______________________

Unit No.______________________

Center______________________

BAYLOR SENIOR HEALTH NETWORK
DALLAS DIAGNOSTIC ASSOCIATION
COMPREHENSIVE EVALUATION INSTRUMENT

Plano, TX

Senior Form 6576 Rev 9/12/05

Medical History

Please circle "Yes" or "No" to indicate whether or not you have or have had any of the conditions below. If "Yes", write the year when each condition began.

Condition			Year Diagnosed	Condition			Year Diagnosed
Stroke	Yes	No	______	Diverticulosis/itis	Yes	No	______
Seizures	Yes	No	______	Irritable Bowel	Yes	No	______
Migraine	Yes	No	______	Kidney problem	Yes	No	______
Hyperthyroid	Yes	No	______	Kidney stone	Yes	No	______
Hypothyroid	Yes	No	______	Urine Incontinence	Yes	No	______
Bronchitis/Emphysema	Yes	No	______	Prostate problems	Yes	No	______
Asthma	Yes	No	______	Cancer	Yes	No	______
Coronary Disease	Yes	No	______	Osteoporosis	Yes	No	______
Heart Failure	Yes	No	______	Osteoarthritis	Yes	No	______
Pacemaker	Yes	No	______	Vertigo/Dizziness	Yes	No	______
Arrhythmia/Atrial Fibrillation	Yes	No	______	Parkinson's	Yes	No	______
High blood pressure	Yes	No	______	Depression	Yes	No	______
Diabetes	Yes	No	______	Anxiety/Stress	Yes	No	______
High Cholesterol	Yes	No	______	Memory problem	Yes	No	______
Peptic Ulcer Disease	Yes	No	______	Ankle/Leg Swelling	Yes	No	______
Hepatitis	Yes	No	______	Other ______________________			
Pancreatitis	Yes	No	______	Other ______________________			
Gallbladder Stones	Yes	No	______	Other ______________________			

Are any of these conditions getting worse? ☐ Yes ☐ No

Do you have any questions regarding these conditions? ☐ Yes ☐ No

At this time, what health problem concerns you most? ______________________________________

____

List all surgeries and hospitalizations

SURGERY/HOSPITALIZATIONS	Month/Year	HOSPITAL

Patient Name___________________________

APN/MD_______________________________

Unit No.______________________________

Center________________________________

Medications

Are you allergic to any medications? ☐ Yes ☐ No

If yes, name of medication(s) ____________________

What happens when you take this medication(s)? ____________________

Do you have any questions about your medications? ☐ Yes ☐ No

Questions: ____________________

____

List all prescription medications that you take. Also list vitamins, supplements, herbal remedies and non-prescription medications such as, Tylenol, Advil, Benadryl, laxatives, etc.

MEDICATION	DOSE	HOW OFTEN?	WHO PRESCRIBED?	REASON?

Patient Name ____________________

APN/MD ____________________

Unit No. ____________________

Center ____________________

Family History

Check if any of your blood relatives have ever had:

Mother	☐ Diabetes	☐ High blood pressure	☐ Heart disease	☐ Cancer	☐ Stroke
Father	☐ Diabetes	☐ High blood pressure	☐ Heart disease	☐ Cancer	☐ Stroke
Brother(s)	☐ Diabetes	☐ High blood pressure	☐ Heart disease	☐ Cancer	☐ Stroke
Sister(s)	☐ Diabetes	☐ High blood pressure	☐ Heart disease	☐ Cancer	☐ Stroke
Children	☐ Diabetes	☐ High blood pressure	☐ Heart disease	☐ Cancer	☐ Stroke

Any other illnesses in your family? ______________________________

Social History

Do you live alone? ☐ Yes ☐ No

If not, who lives with you? ______________________

Do you drive? ☐ Yes ☐ No

What is/was your occupation?______________________

Have you retired? ☐ Yes ☐ No

Education level completed: __________ grade ☐ high school ☐ some college ☐ college

Do you have problems getting to health care appointments? ☐ Yes ☐ No

If so, explain ______________________

Do you have trouble affording or obtaining your medications? ☐ Yes ☐ No

Do you have medication coverage? ☐ Yes ☐ No

Do you have trouble paying your bills? ☐ Yes ☐ No

Do you have insurance, Medicaid, or supplemental funds? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

When did you start smoking? ____________ When did you stop smoking? ____________

How much do you smoke? ______________________

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind and how often?______________________

Have you ever used illegal drugs? ☐ Yes ☐ No

If yes, what kind and how often?______________________

What do you do for exercise?______________________

If you exercise, how many days a week? ☐ daily ☐ 2-3 times weekly ☐ 4-7 times weekly

Do you have any religious, spiritual, or cultural beliefs that will influence the medical care or education you will receive? ☐ Yes ☐ No

If so, what? ______________________

Who is the best person for us to teach? ☐ patient ☐ other______________

Primary language spoken: ☐ English ☐ Other______________

Patient Name______________________

APN/MD______________________

Unit No.______________________

Center______________________

Activities of Daily Life

Do you need help with any of the following activities? (Circle the amount of help needed)

Bathing	Need no help	Need some help	Need total help
Dressing	Need no help	Need some help	Need total help
Eating	Need no help	Need some help	Need total help
Toileting	Need no help	Need some help	Need total help
Transferring	Need no help	Need some help	Need total help

Do you need help with any of the following activities? (Circle the amount of help needed)

Transportation	Need no help	Need some help	Need total help
Meal Preparation	Need no help	Need some help	Need total help
Shopping and Errands	Need no help	Need some help	Need total help
Household Chores	Need no help	Need some help	Need total help
Money Management	Need no help	Need some help	Need total help
Medication Management	Need no help	Need some help	Need total help

Do you have regular homecare service or a caregiver? ☐ Yes ☐ No

If yes, who provides your care (home care agency or individual)? ____________________________

Advance Directives

Do you have a living will? ☐ Yes ☐ No

Do you have a Medical Power of Attorney? ☐ Yes ☐ No

Do you have an out-of-hospital do not resuscitate? ☐ Yes ☐ No

If you answered yes to any of these questions, please bring a copy of the legal document to your first visit. In addition, please complete the questions on the Advance Directive questionnaire.

Nutrition

Are you on a special diet? ☐ Yes ☐ No

If yes, what kind and why? ____________________________

How many drinks with caffeine do you drink daily? (e.g. coffee, tea, sodas)

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5 or more

Do you take any over-the-counter supplements or herbal products? ☐ Yes ☐ No

If yes, what kind and why? ____________________________

Review of Systems

During the last three months, have you had any of the following symptoms or problems?
(circle all that apply):

General – fatigue, malaise, chills, weakness, night sweats, sleep

Skin – rashes, lesions, changes in moles, pressure ulcers

Eyes – eye pain, double vision, floaters, glaucoma, cataracts, blind spots, loss of vision, wear glasses, had other eye surgery

Ears, Nose, Throat – ears ringing or drainage, change in hearing, wear hearing aids, head cold, sinus drainage or trouble, blood sputum, sore throat, hoarse

Endocrine – hot or cold intolerance, frequent urination, excessive thirst

Blood/Lymphatic – anemia, swollen glands, received transfusion

Breasts – lump, pain, nipple discharge

Respiration – coughing, wheezing

Cardiovascular – heart or chest pain, leg or ankle swelling, fast or irregular heart beat, shortness of breath with exertion, become short of breath when just sitting or standing, wake up short of breath, number of pillows with which you sleep _____

Gastrointestinal – stomach pain, swallowing problem, nausea, appetite changes, diarrhea, constipation, vomiting, gas or belching, food intolerance, hemorrhoids or piles, black stools, blood in or on stool, weight gain or loss (Pounds lost or gained ________)

Genitourinary – pain or burning with urination, blood in urine, cloudy or foul-smelling urine, urine slow to start, dribbling, incontinence, problems with sexual activity, sexually transmitted diseases, vaginal bleeding or discharge, penile discharge or bleeding. Have you taken hormone replacement therapy?
Number of times up at night to urinate _____ Number of pregnancies______ Live births ______

Musculoskeletal – back pain, joint pain, broken bones, muscle cramps

Neurological – dizziness, vertigo, loss of balance, severe headache, seizures, coordination problems, numbness or tingling, weakness

Mental health – depression, sadness, lethargy, agitation, insomnia, always worried, nervousness, feelings of hopelessness, thoughts about dying, feel like hurting self, recent death or relocation of family or friends.

Geriatric Syndrome Screen

Question	Yes	No
Do you have unintentional loss of urine?	☐ Yes	☐ No
Do you often feel sad, depressed, or have the blues?	☐ Yes	☐ No
Do you forget recent conversations or events?	☐ Yes	☐ No
Do you repeat or ask the same thing over and over?	☐ Yes	☐ No
Do you have difficulty balancing a checkbook?	☐ Yes	☐ No
Do you have difficulty planning and cooking a meal?	☐ Yes	☐ No
Do you have trouble driving?	☐ Yes	☐ No
Do you get lost outside of the house?	☐ Yes	☐ No
Would you know what to do in case of a fire in your house?	☐ Yes	☐ No
Do you have increasing difficulty finding the right word to express yourself?	☐ Yes	☐ No
Do you have difficulty following conversations?	☐ Yes	☐ No
Do you forget appointments?	☐ Yes	☐ No
Have you fallen in the past year?	☐ Yes	☐ No
If yes, how many times? ___________		
Do you suffer from dizziness?	☐ Yes	☐ No
Do you use any assistive devices?	☐ Yes	☐ No
If yes, please circle devices that you have: cane, walker, wheelchair, electric wheelchair/scooter, bedside commode, hospital bed		
Do you have vision problems?	☐ Yes	☐ No
Do you have hearing problems?	☐ Yes	☐ No
Do you suffer from chronic pain?	☐ Yes	☐ No
Do you take pain medications every day?	☐ Yes	☐ No
Do you take more than six (6) types of medications per day?	☐ Yes	☐ No