Martin Medical Center, P.C.
Functional Activities Questionnaire

Patient Name: _____ Date: _____

Circle Yes or No.

1.	Can you get our of bed without help?	Yes	No
2.	Do you dress yourself without help?	Yes	No
3.	Can you prepare your own meals?	Yes	No
4.	Do you do your own shopping?	Yes	No
5.	Do you write checks and pay your own bills?	Yes	No
6.	Do you drive, or have other means of transportation for traveling outside your neighborhood?	Yes	No
7.	Are you able to keep track of appointments and family occasions?	Yes	No
8.	When you take medicine, are you able to take it according to directions, dosing, etc?	Yes	No
9.	Are you able to keep track of current events?	Yes	No
10.	Are you still able to play games of skill that you enjoy, or work on a favorite hobby?	Yes	No

☐ Provider assessment: No further evaluation needed.
☐ Provider assessment: Referral: _____

_____
Provider's Signature

Martin Medical Center, P.C.
General Intake Questionnaire

Patient Name: _____ Date: _____

Circle Yes or No.

1. Did you receive your flu shot between August of last year and March of this year? Yes No
   If so, where? _____
2. Did you use tobacco products in the last 2 years? Yes No
   *E-cigarettes/vaping does not count Yes No
   If yes, have you received smoking cessation counseling Yes No
3. Have you been screened for colon cancer or blood in the stool in the past 10 years? Yes No
   If yes, where & when? _____
4. If you are a female and your age is between 50 and 74, have you had a mammogram in the last 2 years? Yes No
   If yes, where? _____
5. If you are female between the age of 67 to 85 have you had a fracture of any bone in the last year? Yes No
   If yes, have you had a bone mineral density test or a prescription filled for osteoporosis Medication within 6 months of the fracture date? Yes No
6. Have you been diagnosed with type I or II diabetes? Yes No
   If yes, have you had a dilated or retinal eye exam by an optometrist/ophthalmologist or a RetinaVue eye screen from your PCP this year or a negative retinal exam last year? Yes No
   If yes, where? _____
7. Have you been discharged from a hospital, rehab facility or skilled nursing facility since your last visit? Yes No
   If so, from where: _____
9. Do you have a living will? Yes No

_____ _____

Provider's Signature Date

Martin Medical Center, P.C.
Screening for Depression

Patient Name: _____ Date: _____

Over the past two weeks, how often have you been bothered by any of the following problems? (for each question, circle the number that represents the best answer.)

	Not at all	Several Days	More than one half of the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things such as reading a newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people have noticed. Or the opposite… being so fidgety or restless that you have been Moving around a lot more that usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you have had any of these problems, how difficult have they 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

☐ Provider assessment: No further evaluation needed.
☐ Provider assessment: Referral: _____

_____
Provider's Signature

Martin Medical Center, P.C.
Screening for Risk for Falls

Patient Name: _____ Date: _____

Circle Yes or No.

1.	Do you notice numbness in your feet?	Yes	No
2.	Do your steps feel "heavy" when you walk?	Yes	No
3.	Do you ever feel light-headed upon arising from a seated position?	Yes	No
4.	When walking, can you start and stop without difficulty?	Yes	No
5.	Do you have trouble getting out of a chair?	Yes	No
6.	Do you have any kind of difficulty when walking?	Yes	No
7.	Do you ever lose your balance with movements such as bending over, turning around, etc.?	Yes	No
8.	Have you ever fallen in the past?	Yes	No

Provider assessment: If the above answers represent risk of falling, perform the "get up and go" test: Have the patient get up from the chair, not using their own arms, walk a few yards, and return. Grade the exercise on a sale of 1 to 5 with 1 being normal and 5 being severely abnormal. Based on this test, decide if the patient needs further evaluation/referral.

☐ Provider assessment: No further evaluation needed.
☐ Provider assessment: Referral: _____

_____
Provider's Signature

Martin Medical Center, P.C.
Screening for Hearing Loss

Patient Name: _____ Date: _____

Circle Yes or No.

1.	Do you have a problem hearing over the telephone?	Yes	No
2.	Do you have trouble following the conversation when two or more people talk at the same time?	Yes	No
3.	Do people complain that you turn the T.V. volume up too high?	Yes	No
4.	Do you have to strain to understand conversation?	Yes	No
5.	Do you have trouble hearing in a noisy background?	Yes	No
6.	Do you find yourself asking people to repeat themselves?	Yes	No
7.	Do many people you talk to seem to mumble, or not speak clearly?	Yes	No
8.	Do you misunderstand what others are saying and respond inappropriately?	Yes	No
9.	Do you have trouble understanding the speech of women and children?	Yes	No
10.	Do people get annoyed because you misunderstand what they say?	Yes	No

☐ Provider assessment: No further evaluation needed.
☐ Provider assessment: Referral: _____

_____
Provider's Signature

Martin Medical Center, P.C.
Home Safety Questionnaire

Patient Name: _____ Date: _____

Circle Yes or No.

1.	Do you have throw rugs on hardwood floors in your home?	Yes	No
2.	Do you have pets that stay indoors?	Yes	No
3.	Does your house have smoke alarms in good working order?	Yes	No
4.	Does your bathtub contain safety measures such as a rubber mat or strips?	Yes	No
5.	Is the area in front of your bathtub either carpeted or protected by a bath mat with rubber backing?	Yes	No
6.	Do you have night lights in your house?	Yes	No
7.	Do you have loose or frayed cords or overloaded electrical sockets in your house?	Yes	No
8.	Do you unplug household appliances when not in use?	Yes	No
9.	Do you keep medicines in a safe place and have their directions clearly labeled?	Yes	No
10.	Do you keep knives and other sharp objects put away in a safe place?	Yes	No
11.	Do you keep poisons, chemicals or other toxic substances put away in a safe place?	Yes	No
12.	Do you have furniture, such as a coffee table with sharp corners or a rickety chair, that could cause injury?	Yes	No

☐ Provider assessment: No further evaluation needed.
☐ Provider assessment: Referral: _____

_____
Provider's Signature