

6. Please check (✓) if you have experienced any of the following over the last week:

Constitutional

- Fever
- Weight loss (>10 lbs.)
- Fatigue

Eyes / Mouth

- Dry eyes
- Red or inflamed eyes
- Ulcers in the mouth
- Dry mouth

Respiratory

- Shortness of breath
- Cough
- Pain with breathing

Cardiovascular

- Chest pain

Skin

- Rash
- Loss of hair

7. How often do you exercise aerobically (sweating, increased heart rate, shortness of breath) for at least one-half hour (30 minutes)? Please check (✓) only one.

- 3 or more times a week
- 1-2 times per week
- 1-2 times per month
- Do not exercise regularly
- Cannot exercise due to disability/ handicap

8. Please place a check (✓) in the appropriate spot to indicate the amount of pain you are having today in each of the joint areas listed below:

	<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>		<u>None</u>	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
LEFT FINGERS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT FINGERS	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT WRIST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT WRIST	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT ELBOW	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT ELBOW	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT SHOULDER	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT SHOULDER	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT HIP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT HIP	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT KNEE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT KNEE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT ANKLE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT ANKLE	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
LEFT TOES	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	RIGHT TOES	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
NECK	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	BACK	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

9. Please write below any new drugs or medicines that have changed since your last visit.

<u>NEW MEDICATION</u>	<u>DOSE</u>	<u>How many per day or week</u>	<u>DISCONTINUED MEDICATION</u>	<u>MEDICINE NEEDING REFILLS</u>
1. _____	_____	_____	1. _____	1. _____
2. _____	_____	_____	2. _____	2. _____
3. _____	_____	_____	3. _____	3. _____

DRUG ALLERGIES _____

10. Over the last 6 months, have you had: [please check (✓)]

- | | | | | | |
|---------------------------------------|-----------------------------|------------------------------|----------------------------------|-----------------------------|------------------------------|
| An operation or new illness | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Side effects of any drugs | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| A patient visit or stay at a hospital | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Smoke cigarettes regularly | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| An important new symptom | <input type="checkbox"/> No | <input type="checkbox"/> Yes | A fall, accident or other trauma | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Please explain any "Yes" answers below:

11. Are you currently or were you recently in a skilled nursing facility or hospice, If so please provide the dates below.

Start Date: _____

Leave Date: _____

Facility Name: _____

Address: _____

Phone # _____

Case Worker's Name: _____