



**NEWPORT FAMILY MEDICINE 520 Superior Drive Suite 360  
Newport Beach CA 92663 (949) 644-1025 FAX (949) 644-7852**

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**Hearing**

**Circle Response**

Do you have trouble hearing the TV or telephone when others do not?      Yes      No

Do you have to strain to hear/understand conversations?      Yes      No

**Home Safety**

Does your home have “throw” rugs?      Yes      No

Do you use a non-slip bath mat in the tub or shower?      Yes      No

Do you have handrails on all steps and stairs?      Yes      No

Does your home have working smoke detectors?      Yes      No

**Balance**

Have you had a fall in the last year or feel unsteady on your feet?      Yes      No

**Daily Routine**

Do you live alone?      Yes      No

Do you need help with any of the following? (Please circle all that apply)

- |                   |                        |                        |         |
|-------------------|------------------------|------------------------|---------|
| Preparing meals   | Shopping               | Driving/transportation | Bathing |
| Walking distances | Managing your finances |                        |         |

**Cognitive Health**

Do you have any concerns about your memory or other cognitive functions?      Yes      No

Please circle any of these tasks that you are having difficulty with:

- |                                                                                        |                            |                          |                |
|----------------------------------------------------------------------------------------|----------------------------|--------------------------|----------------|
| Remembering to take medication                                                         | Recalling past events      | Recalling names          | Word retrieval |
| Recalling historic events or dates                                                     | Getting lost while driving | Remembering appointments |                |
| Completing Complex tasks (preparing taxes, planning projects, balancing the checkbook) |                            |                          |                |

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**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Compared to 10 years ago, my memory is: (circle response)

- |                            |                 |
|----------------------------|-----------------|
| A lot worse                | A little better |
| A little worse             | A lot better    |
| About the same (no change) | Not Certain     |

**How are you feeling?**

During the past 4 weeks, have you been bothered by emotional problems

such as feeling anxious, depressed, irritable, sad or downhearted and blue? Yes    No

Have you lost interest in activities you usually enjoy? Yes    No

Have you had a loss or increase in your appetite? Yes    No

Have you had any problems with insomnia or sleeping excessively? Yes    No

**Are you a smoker?**

Yes \_\_\_\_\_ No \_\_\_\_\_ Yes, but I'm ready to quit \_\_\_\_\_

**During the PAST 4 WEEKS, how many drinks of wine, beer or other alcoholic beverages did you have?**

None \_\_\_\_\_ 1 drink or less per week \_\_\_\_\_ 2-5 per week \_\_\_\_\_

6-9 per week \_\_\_\_\_ 10 or more per week \_\_\_\_\_

**Vision Assessment**

Have you seen an optometrist or ophthalmologist in the last year? Yes    No

If not, we will have one of our staff check your vision today:

	<b><u>Uncorrected</u></b>	<b><u>Corrected</u></b>
Right Eye (OD)	_____	_____
Left Eye (OS)	_____	_____
Both eyes (OU)	_____	_____

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**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Health Screening Exams**

Please list the date and findings of your most recent:

**Colonoscopy** \_\_\_\_\_

**PSA and Rectal exam (males)** \_\_\_\_\_

**Mammogram/Pap Smear (females)** \_\_\_\_\_

**Bone Density test (DEXA)** \_\_\_\_\_

**Vaccines**

Please list the date you last received this vaccine:

**Tetanus:** Td (Tetanus/Diphtheria) or Tdap (Tetanus/Diphtheria/Pertusis) \_\_\_\_\_

**Pneumovax:** pneumonia vaccine \_\_\_\_\_

**Zostavax:** Shingles vaccine \_\_\_\_\_

**Influenza:** flu shot \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_