STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

CLINIC MULTISPECIALITY MEDICARE HEALTH ASSESSMENT QUESTIONNAIRE

Please answer the following questions to the best of your ability.

1. In general, how would you rate your overall health?

❑ Excellent	❑ Very good	❑ Good	❑ Fair	❑ Poor

2. In general, how would you rate your quality of life?

❑ Excellent	❑ Very good	❑ Good	❑ Fair	❑ Poor

3. In general, how would you rate your mental health, including your mood and your ability to think?

❑ Excellent	❑ Very good	❑ Good	❑ Fair	❑ Poor

4. In the ***past 7 days***, how much did pain interfere with your day to day activities?

❑ Not at all	❑ A little bit	❑ Somewhat	❑ Quite a bit	❑ Very Much

5. Over the ***last 2 weeks***, how often have you been bothered by any of the following problems?

Problem	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				

6. Because of a health or physical problem, do you have any difficulty doing the following activities ***without special equipment or help from another person***?

Activity	No, I do not have difficulty	Yes, I have difficulty	I am not able to do this activity unassisted
Bathing			
Dressing and grooming			
Eating			
Using the toilet			
Getting in and out of bed or chairs			
Managing medications			
Managing money			
Household activities, like food prep, laundry, housekeeping			

7. In the ***past 6 months***, have you accidentally leaked urine? ❑ YES ❑ NO

8. A fall is when your body goes to the ground or floor without being pushed.

   Did you fall in the ***past 12 months***? ❑ YES ❑ NO

9. Walking Status:

❑ Walk unassisted	❑ Use cane, walker, crutches	❑ Use a wheelchair, scooter

10. Do you think you have a hearing problem, or do others think you have a hearing problem?
❑ YES ❑ NO

11. Do you have difficulty driving, watching TV, reading, or doing any of your daily activities because of your eyesight? ❑ YES ❑ NO

12. How many servings of fruits and vegetables do you eat in a typical day?

❑ More than 5 servings	❑ 3-5 servings	❑ 1-2 servings	❑ I do not eat fruits and vegetables

13. Does the place where you live have the following safety concerns addressed?

Safety Concerns	YES	NO
Loose rugs		
Carbon monoxide detector		
Working smoke alarm		
Good lighting in walkways		
Solid hand rails on stairs		
Non-slip flooring in tub or shower, or grab bars		

14. What is your usual form of transportation?

❑ Drive self	❑ Driven by others	❑ Bus/taxi/ para-transit/bike

15. Do you have an Advance Healthcare Directive? ❑ YES ❑ NO

16. Is your Advance Healthcare Directive on file with us? ❑ YES ❑ NO

17. To ensure optimal care coordination, please list below all providers you see on a regular basis:

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18. Please draw a clock with all of the numbers, with hands indicating the time is ten to two.

DATE	TIME	SIGNATURE (Patient /Legal Designated Representative)

PRINT NAME	RELATIONSHIP TO PATIENT

IF THIS DOCUMENT WAS INTERPRETED:
Interpreter used:

PRINT SHC in-person interpreter name	Video or TEL Interpreter ID#	Language

DATE	TIME	PHYSICIAN SIGNATURE	PRINT NAME