marinhealth Medical Network | UCSF Health

Self-Reported Health Status

We want to ask you some questions about your health. Please place a check next to your selected answers. Thank You!

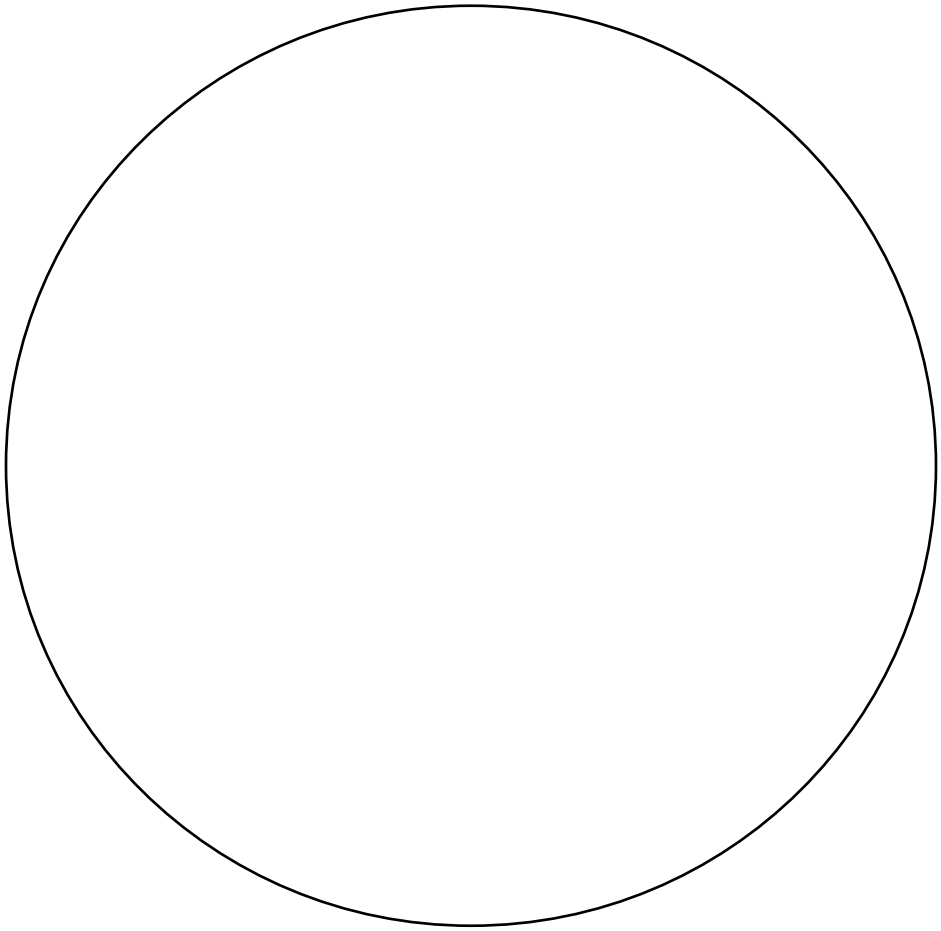
Patient Name: _____ DOB: _____

Question	Choices
In general, would you say your health is:	☐ Excellent ☐ Very good ☐ Fair ☐ Poor ☐ Not answered
Do you feel you have hearing loss?	☐ Yes ☐ No ☐ Not answered
Behavioral Risks	
Without intending to, have you gained or lost weight during the past 3 months?	☐ Yes – more than 6 lbs ☐ Yes – 2-6 lbs ☐ No ☐ Unknown ☐ Not answered
Has your food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?	☐ Yes – a lot ☐ Yes – a little ☐ No ☐ Not answered
How many times a week do you usually do 30 minutes or more of moderate or vigorous-intensity physical activity or walking that increases your heart rate or makes you breathe harder than normal? (e.g., jogging, aerobics, bicycling, carrying light loads,	☐ 5 or more times a week ☐ 3 – 4 times a week ☐ 1 – 2 times a week ☐ None Not answered
Do you wear a seat belt when in a vehicle?	☐ Always ☐ Sometimes ☐ No ☐ Not answered

Do you experience urinary leakage when coughing, laughing, running or stooping?	☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never ☐ Not answered
Do you experience urinary leakage before reaching the toilet?	☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never ☐ Not answered
Activities of Daily Living	
Have you fallen since your last visit or within the last year? If yes, did the fall result in injury?	☐ No ☐ Yes, without injury ☐ Yes, with injury (comment) ☐ Not applicable (Pediatric)
Do you feel unsteady when standing or walking?	☐ Yes ☐ No ☐ Not answered
Do you worry about falling?	☐ Yes ☐ No ☐ Not answered
In the past 7 days, did you need help from others to perform everyday activities? (multiple choice)	☐ Eating ☐ Getting dressed ☐ Grooming ☐ Bathing ☐ Walking ☐ Using toilet ☐ Not answered
In the past 7 days, did you need help from others to take care of any of the following things? (multiple choice)	☐ Laundry ☐ Housekeeping ☐ Finances ☐ Shopping ☐ Using the telephones ☐ Food preparation ☐ Transportation ☐ Not answered

Psychosocial Risks	
Do you have any concerns about the followings? (multiple choice)	☐ Stress ☐ Anger ☐ Pain ☐ Fatigue ☐ Not answered
Do you have any concerns about sexual health?	☐ Yes ☐ No ☐ Not answered
Do you have someone who would be able to help you in case of emergency?	☐ Yes ☐ No ☐ Maybe ☐ Not answered
Do you have someone to trust and confide in?	☐ Yes ☐ No ☐ Maybe ☐ Not answered
Do you feel safe at home?	☐ Yes ☐ No ☐ Not always ☐ Not answered
Over the last 2 weeks, how often have you been bothered by any of the following problems? Little interest or pleasure in doing things	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling down, depressed, or hopeless	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

PLEASE DRAW A CLOCK AND PLACE THE HANDS AT 10 O'CLOCK



Please give this completed questionnaire to your Medical Assistant.
Thank you so much!