# Staying Healthy Assessment

## Senior

| Patient's Name (first & last) | Date of Birth | ☐ Female ☐ Male | Today's Date |
|---|---|---|---|
| Person Completing Form *(if patient needs help)* | ☐ Family Member ☐ Friend ☐ Other *Please specify:* | | Need help with form? ☐ Yes ☐ No |

*Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.*

Need Interpreter? ☐ Yes ☐ No

| | | | | | ***Clinic Use Only:*** |
|---|---|---|---|---|---|
| 1 | Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu? | Yes | No | Skip | Nutrition |
| 2 | Do you eat fruits and vegetables every day? | Yes | No | Skip | |
| 3 | Do you limit the amount of fried food or fast food that you eat? | Yes | No | Skip | |
| 4 | Are you easily able to get enough healthy food? | Yes | No | Skip | |
| 5 | Do you drink a soda, juice drink, sports or energy drink most days of the week? | No | Yes | Skip | |
| 6 | Do you often eat too much or too little food? | No | Yes | Skip | |
| 7 | Do you have difficulty chewing or swallowing? | No | Yes | Skip | |
| 8 | Are you concerned about your weight? | No | Yes | Skip | |
| 9 | Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day? | Yes | No | Skip | Physical Activity |
| 10 | Do you feel safe where you live? | Yes | No | Skip | Safety |
| 11 | Do you often have trouble keeping track of your medicines? | No | Yes | Skip | |
| 12 | Are family members or friends worried about your driving? | No | Yes | Skip | |
| 13 | Have you had any car accidents lately? | No | Yes | Skip | |
| 14 | Do you sometimes fall and hurt yourself, or is it hard to get up? | No | Yes | Skip | |
| 15 | Have you been hit, slapped, kicked, or physically hurt by someone in the past year? | No | Yes | Skip | |
| 16 | Do you keep a gun in your house or place where you live? | No | Yes | Skip | |
| 17 | Do you brush and floss your teeth daily? | Yes | No | Skip | Dental Health |
| 18 | Do you often feel sad, hopeless, angry, or worried? | No | Yes | Skip | Mental Health |
| 19 | Do you often have trouble sleeping? | No | Yes | Skip | |

| | | | | | |
|---|---|---|---|---|---|
| 20 | Do you or others think that you are having trouble remembering things? | No | Yes | Skip | |
| 21 | Do you smoke or chew tobacco? | No | Yes | Skip | Alcohol, Tobacco, Drug Use |
| 22 | Do friends or family members smoke in your house or where you live? | No | Yes | Skip | |
| 23 | In the past year, have you had 4 or more alcohol drinks in one day? | No | Yes | Skip | |
| 24 | Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight? | No | Yes | Skip | |
| 25 | Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.? | No | Yes | Skip | Sexual Issues |
| 26 | Have you or your partner(s) had sex with other people in the past year? | No | Yes | Skip | |
| 27 | Have you or your partner(s) had sex without a condom in the past year? | No | Yes | Skip | |
| 28 | Have you ever been forced or pressured to have sex? | No | Yes | Skip | |
| 29 | Do you have someone to help you make decisions about your health and medical care? | Yes | No | Skip | Independent Living |
| 30 | Do you need help bathing, eating, walking, dressing, or using the bathroom? | No | Yes | Skip | |
| 31 | Do you have someone to call when you need help in an emergency? | Yes | No | Skip | |
| 32 | Do you have other questions or concerns about your health? | No | Yes | Skip | Other Questions |

*If yes, please describe:*

| ***Clinic Use Only*** | Counseled | Referred | Anticipatory Guidance | Follow-up Ordered |
|---|---|---|---|---|
| ☐ Nutrition | ☐ | ☐ | ☐ | ☐ |
| ☐ Physical activity | ☐ | ☐ | ☐ | ☐ |
| ☐ Safety | ☐ | ☐ | ☐ | ☐ |
| ☐ Dental Health | ☐ | ☐ | ☐ | ☐ |
| ☐ Mental Health | ☐ | ☐ | ☐ | ☐ |
| ☐ Alcohol, Tobacco, Drug Use | ☐ | ☐ | ☐ | ☐ |
| ☐ Sexual Issues | ☐ | ☐ | ☐ | ☐ |
| ☐ Independent Living | ☐ | ☐ | ☐ | ☐ |

Comments:

☐ **Patient Declined the SHA**

| PCP's Signature: | Print Name: | Date: |
|---|---|---|

**SHA ANNUAL REVIEW**

| PCP's Signature: | Print Name: | Date: |
|---|---|---|
| PCP's Signature: | Print Name: | Date: |
| PCP's Signature: | Print Name: | Date: |
| PCP's Signature: | Print Name: | Date: |