Office Use

Height ____________	BP ______________	Resp ____________
Weight ____________	Pulse ____________	Temp ____________

Are you having pain today? **YES / NO**

If so, where? ____

How bad is the pain, on a scale of 1 to 10? **1 2 3 4 5 6 7 8 9 10**

Are you allergic to any medications or products? ____

(such as latex, shellfish, or iodine) ____

What medications are you currently taking? ____

____

____

____

____

What pharmacy do you prefer to use? ____

How far did you get in school?

NONE
HIGH SCHOOL
SOME COLLEGE
COLLEGE DEGREE
POST-GRADUATE DEGREE

Do you feel unsafe at home? **YES / NO**

Do you have an Advance Directive? **YES / NO**

(a legal statement of a person's wishes regarding possible future medical treatment)

Do you have any learning difficulties?

No	**Fatigue**	**Poor reading**
Illness	**Money problems**	**Poor memory**
Poor thinking	**Poor hearing**	**Poor vision**
Cultural barrier	**Language barrier**	**Other**
Desire/Motivation	**Poor math skills**	
Poor concentration	**Poor health knowledge**	
Emotional state	**Poor problem solving**	

If you are at least 65, have you fallen in the past year? **YES / NO**