PATIENT NAME: _____ DOB: _____

18 years and older: MIPS

BMI: Current Height: _____ Current Weight: _____

DIABETES: Are you Diabetic?: ☐ **YES** ☐ **NO** HgA1C if available_____

Date of your last Diabetic **Eye** Exam? _____ Performed By? _____

Date of your last Diabetic **Foot** Exam? _____ Performed By? _____

TOBACCO USE: Do you Smoke? ☐ **YES** ☐ **NO**

BLOOD PRESSURE: Do you have High Blood Pressure?: ☐ **YES** ☐ **NO**

IMMUNIZATIONS: 1. Did you receive the Influenza Vaccine?

☐ **YES:** If yes, date received: _____

☐ **NO:** ☐ Vaccine not available or ☐ Reason why not previously received: _____

2. Did you receive the Pneumonia Vaccine? **(65 yrs and older)**

☐ **YES** ☐ **NO** If yes, date received: _____

ADVANCED CARE PLANNING: Do you have a Living will, DNR, or Power of Attorney for healthcare?

☐ **YES** ☐ **NO** If yes, name and relation to administrator: _____

50 years and older: PERIPHERAL ARTERY DISEASE QUESTIONNAIRE

1. ☐ **YES** ☐ **NO** Do you have high cholesterol or are you on cholesterol medication?

2. ☐ **YES** ☐ **NO** Do you have a history of aortic aneurysm?

3. ☐ **YES** ☐ **NO** Do you have a family history of diabetes, high blood pressure, or aortic aneurysm?

4. ☐ **YES** ☐ **NO** Have you ever had a stroke, mini-stroke, or heart attack?

5. ☐ **YES** ☐ **NO** Do you experience aching, cramping, or pain in your legs, thighs, or buttocks when you walk or exercise?

a. ☐ **YES** ☐ **NO** If yes, does the pain improve with rest?

6. ☐ **YES** ☐ **NO** Do you experience cramping, tightness, “Charlie horses” or pain in the legs or feet when lying down?

a. ☐ **YES** ☐ **NO** If yes, does the pain improve when you stand up?

7. ☐ **YES** ☐ **NO** Do you have numbness and tingling in the lower legs and feet?

8. ☐ **YES** ☐ **NO** Are your toes pale, discolored, or bluish?

9. ☐ **YES** ☐ **NO** Are your feet cold to the touch?

10. ☐ **YES** ☐ **NO** Do you have sores or ulcers on your legs or feet that do NOT heal?

65 years and older: ARE YOU AT RISK FOR FALLING?

1. ☐ **YES (2)** ☐ **NO (0)** I have fallen in the past year

2. ☐ **YES (2)** ☐ **NO (0)** I use or have been advised to use a cane or walker to get around safely

3. ☐ **YES (1)** ☐ **NO (0)** Sometimes I feel unsteady when I am walking

4. ☐ **YES (1)** ☐ **NO (0)** I steady myself by holding onto furniture when walking at home

5. ☐ **YES (1)** ☐ **NO (0)** I am worried about falling

6. ☐ **YES (1)** ☐ **NO (0)** I need to push with my hands to stand up from a chair

7. ☐ **YES (1)** ☐ **NO (0)** I have some trouble stepping up onto curb

8. ☐ **YES (1)** ☐ **NO (0)** I often have to rush to the toilet

9. ☐ **YES (1)** ☐ **NO (0)** I have lost some feeling in my feet

10. ☐ **YES (1)** ☐ **NO (0)** I take medicine that sometimes makes me feel light-headed or more tired than usual

11. ☐ **YES (1)** ☐ **NO (0)** I take medicine to help me sleep or improve my mood

12. ☐ **YES (1)** ☐ **NO (0)** I often feel sad or depressed

Total Points:_____

OFFICE USE
MA:_____ DATE:_____
RECEPTIONIST:_____ DATE:_____