South Shore
Medical Center

Patient Label

Adult Patient Questionnaire Addendum

Patient's Name:	Date of Birth:		
	Date of Visit:		
Question	**Response**		**Additional Comments**
1. Are you bed or wheelchair confined?	❑ No	❑ Yes	
2. Do you use an assistive device such as a cane or walker?	❑ No	❑ Yes	
3. Have you fallen in the past year?	❑ No	❑ Yes	
4. Do you have difficulty walking, getting out of a bed or chair?	❑ No	❑ Yes	
5. Are you afraid of falling?	❑ No	❑ Yes	
6. Have you broken any bones in the past year?	❑ No	❑ Yes	
7. Do you protect yourself from the sun when you are outdoors?	❑ No	❑ Yes	
8. Because of a health or physical problem, do you need help to: • Shop? • Do light housework? • Walk across a room? • Take a bath or shower? • Manage the household finances?	 ❑ No ❑ No ❑ No ❑ No ❑ No	 ❑ Yes ❑ Yes ❑ Yes ❑ Yes ❑ Yes	
9. Do you experience incontinence (lose urine)? • Have accidents or wear pads?	❑ No ❑ No	❑ Yes ❑ Yes	
10. Do you have someone to help you if you become ill?	❑ No	❑ Yes	If yes, who?
11. Do you have someone to make decisions for you if you become unable to?	❑ No	❑ Yes	If yes, who?
12. Over the last two weeks, have you had little interest or pleasure in doing things?	❑ Not at all ❑ More than half the days		❑ Several days ❑ Nearly every day
13. Over the last two weeks, have you felt "down", depressed, or hopeless?	❑ Not at all ❑ More than half the days		❑ Several days ❑ Nearly every day
14. Over the last two weeks how often have you had trouble falling or staying asleep, or sleeping too much?	❑ Not at all ❑ More than half the days		❑ Several days ❑ Nearly every day
15. Over the last two weeks how often have you felt tired or had little energy?	❑ Not at all ❑ More than half the days		❑ Several days ❑ Nearly every day
16. Over the last two weeks how often did you have a poor appetite or overeat?	❑ Not at all ❑ More than half the days		❑ Several days ❑ Nearly every day

Please complete both sides of this form

17. Over the last two weeks, have you felt bad about yourself – or felt that you are a failure and have let yourself or your family down?	❑ Not at all ❑ More than half the days	❑ Several days ❑ Nearly every day
18. Over the last two weeks, have you had trouble concentrating on things such as reading the newspaper or watching television?	❑ Not at all ❑ More than half the days	❑ Several days ❑ Nearly every day
19. Over the last two weeks have you moved or spoken so slowly that other people could have noticed? Or the opposite – have you been so fidgety or restless that you have moved around a lot more than usual?	❑ Not at all ❑ More than half the days	❑ Several days ❑ Nearly every day
20. Over the last two weeks have you had thoughts that you would be better off dead or of hurting yourself?	❑ Not at all ❑ More than half the days	❑ Several days ❑ Nearly every day
21. Over the last two weeks how difficult has it been for you to do your work, take care of things at home, or get along with other people?	❑ Not difficult at all ❑ Very difficult	❑ Somewhat difficult ❑ Extremely difficult

22. How many days a week do you usually exercise?

22a. On days you exercise, how many minutes and/or hours do you usually exercise?

22b. How intense is your typical exercise? ❑ Light (ex. stretching or slow walking) ❑ Moderate (ex. brisk walking) ❑ Heavy (ex. jogging or swimming) ❑ Very heavy (ex.fast running) ❑ I am currently not exercising

23. On a typical day, how many servings of fruits and/or vegetables do you eat? _____ servings per day

23a. On a typical day, how many servings of fried or high-fat foods do you eat? _____ servings per day

23b. On a typical day, how many servings of high fiber or whole grain foods do you eat? _____ servings per day

24. In general, how would you rate your health? ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

Current Physicians

25. Please list the names of physicians you currently see or have appointments and the reason you see them.

Physician Name (First & Last)	Phone Number	City/Town	Reason You See This Physician
Example: Dr. John Jones	***781-234-5678***	***Norwell***	***Annual Eye Exam***

Patient Signature:	**Date:**
FOR OFFICE USE ONLY	
Reviewed by:	**Date:**

Partnering with our patients to make it easier to be healthy