Older Americans Resource & Services

Patient Name: _____ **Date:** _____

Patient ID: _____

Your Health

Instructions: *We would like to ask you a few questions about any health problems you might have. Do you have any of the following illnesses at the present time? Please fill in the appropriate box (yes or no). If you fill in 'yes,' please tell us how much the illness interferes with your activities: Not at All, Somewhat, or A Great Deal. Fill in the appropriate box.*

			If you have the illness, how much does it interfere with your activities?		
	NO	**YES**	**NOT AT ALL**	**SOMEWHAT**	**A GREAT DEAL**
1. Other cancers or leukemia	☐	☐ ▶	☐	☐	☐
2. Arthritis or rheumatism	☐	☐ ▶	☐	☐	☐
3. Glaucoma	☐	☐ ▶	☐	☐	☐
4. Emphysema or chronic bronchitis	☐	☐ ▶	☐	☐	☐
5. High blood pressure	☐	☐ ▶	☐	☐	☐
6. Heart disease	☐	☐ ▶	☐	☐	☐
7. Circulation trouble in arms or legs	☐	☐ ▶	☐	☐	☐
8. Diabetes	☐	☐ ▶	☐	☐	☐
9. Stomach or intestinal disorder	☐	☐ ▶	☐	☐	☐
10. Osteoporosis	☐	☐ ▶	☐	☐	☐
11. Chronic liver or kidney disease	☐	☐ ▶	☐	☐	☐
12. Stroke	☐	☐ ▶	☐	☐	☐
13. Depression	☐	☐ ▶	☐	☐	☐

14. How is your eyesight *(with glasses or contacts)?*

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Totally blind

If Fair, Poor or Totally blind, how much does it interfere with your activities?

NOT AT ALL	**SOMEWHAT**	**A GREAT DEAL**
☐	☐	☐

15. How is your hearing *(with a hearing aid, if needed)?*

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Totally deaf

If Fair, Poor or Totally deaf, how much does it interfere with your activities?

NOT AT ALL	**SOMEWHAT**	**A GREAT DEAL**
☐	☐	☐