Michigan Neurology Associates, P.C.

Patient: _____ DOB: _____

THE EPWORTH SLEEPINESS SCALE

Using the following scale of 0-3, rate the following situations:

0= would never doze 1= sight chance of dozing
2= moderate chance of dozing 3= high chance of dozing

Situation:	**Chance of dozing:**
1. Sitting and reading	___
2. Watching TV	___
3. Sitting inactive in a public place	___
4. As a passanger in a car for an hour without a break	___
5. Lying down to rest in the afternoon	___
6. Sitting and talking to someone	___
7. Sitting quietly after lunch without alcohol	___
8. In a car, while stopped for a few minutes	
9. In traffic	___

Total: ____

Screening Fall Risk

Patients 65+ Years

1. Have you had 2 or more falls in the last 12 months? **YES / NO**
2. Were you injured during a fall this year? **YES / NO**
3. Do you use: ***Cane Walker Wheelchair***
4. Do you feel unsteady when you stand/walk? **YES / NO**
5. Any recent loss or change in vision or hearing? **YES / NO**

Immunization

Last Influenza Vaccination: ____/_____/_____ (or not completed)
Last Pneumonia Vaccination: ____/____/_____ (or not completed)

Depression Screening, Part 2

Over the *last two weeks*, how often have you been bothered by any of the following problems?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total Score: _____

Preventative care

Females:

Have you had a Mammogram: Yes / No

Date: ____/____/_____

Result: _____

Are you diabetic? Yes / No

Hemoglobin A1C result: _____%

Date: ____/____/_____

Colon cancer screening?
Yes / No

Examples: (circle which applies)

Stool smear in office
Cologuard (send in stool sample)
Sigmoidoscopy
Colonoscopy

Date: ____/____/____
Result: _____