State of California - Health and Human Services Agency | Department of Health Care Services

Staying Healthy Assessment

Senior

Today's Date

_____

First Name _____ **Middle Name / MI** _____ **Last Name** _____

Date of Birth _____ **Sex** _____

Person Completing Form (if patient needs help)

- ○ Family Member
- ○ Friend
- ○ Other

Other _____

Need help with form?

- ○ Yes
- ○ No

Need Interpreter?

- ○ Yes
- ○ No

Please answer all the questions on this form as best you can. Select "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

1. Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk or tofu?

- ○ Yes
- ○ No
- ○ Skip

2. Do you eat fruits and vegetables every day?

- ○ Yes
- ○ No
- ○ Skip

3. Do you limit the amount of fried food or fast food that you eat?

- ○ Yes
- ○ No
- ○ Skip

4. Are you easily able to get enough healthy food?

- ○ Yes
- ○ No
- ○ Skip

5. Do you drink a soda, juice drink, sports or energy drink most days of the week?

- ○ Yes
- ○ No
- ○ Skip

6. Do you often eat too much or too little food?

- ○ Yes
- ○ No
- ○ Skip

7. Do you have difficulty chewing or swallowing?

- Yes
- No
- Skip

8. Are you concerned about your weight?

- Yes
- No
- Skip

9. Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least 1/2 hour a day?

- Yes
- No
- Skip

10. Do you feel safe where you live?

- Yes
- No
- Skip

11. Do you often have trouble keeping track of your medicines?

- Yes
- No
- Skip

12. Are family members or friends worried about your driving?

- Yes
- No
- Skip

13. Have you had any car accidents lately?

- Yes
- No
- Skip

14. Do you sometimes fall and hurt yourself, or is it hard to get up?

- Yes
- No
- Skip

15. Have you been hit, slapped, kicked, or physically hurt by someone in the past year?

- Yes
- No
- Skip

16. Do you keep a gun in your house or place where you live?

- Yes
- No
- Skip

17. Do you brush and floss your teeth daily?

- Yes
- No
- Skip

18. Do you often feel sad, hopeless, angry, or worried?

- Yes
- No
- Skip

19. Do you often have trouble sleeping?

- Yes
- No
- Skip

20. Do you or others think that you are having trouble remembering things?

- Yes
- No
- Skip

21. Do you smoke or chew tobacco?

- Yes
- No
- Skip

22. Do friends or family members smoke in your house or where you live?

- Yes
- No
- Skip

23. In the past year, have you had 4 or more alcohol drinks in one day?

- Yes
- No
- Skip

24. Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?

- Yes
- No
- Skip

25. Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?

- Yes
- No
- Skip

26. Have you or your partner(s) had sex with other people in the past year?

- Yes
- No
- Skip

27. Have you or your partner(s) had sex without a condom in the past year?

- Yes
- No
- Skip

28. Have you been forced or pressured to have sex?

- Yes
- No
- Skip

29. Do you have someone to help you make decisions about your health and medical care?

- Yes
- No
- Skip

30. Do you need help bathing, eating, walking, dressing, or using the bathroom?

- Yes
- No
- Skip

31. Do you have someone to call when you need help in an emergency?

- Yes
- No
- Skip

32. Do you have other questions or concerns about your health?

- Yes
- No
- Skip

If yes, please describe:

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