Health Risk and Preventive Care Assessment

年度會員健康風險及疾病預防評估問卷

Patient (Last, First) Name 姓名	Date of Birth 生日	Date of Service 日期	Sex 性別
_____	_____	_____	□ M 男 | □ F 女

My overall health condition is 我覺得我的整體健康狀況是	□ Excellent 非常好	□ Good 良好	□ Fair 一般	□ Poor 差

Please answer questionnaires 1-23 below as the preceding statement pertains to you and please speak with your doctor if any question. 請回答下面的問卷 1-23 題, 因為是與您健康息息相關，如果您有任何疑問，請與您的醫生交談

Diet 飲食			
1	I eat three balanced meals a day that includes fruits, vegetables, grains, and calcium rich foods. 我三餐固定，營養均衡。每天都有攝取蔬菜、水果、穀物及高纖高鈣食品。	Yes 是	No 否
2	I limit eating fried or fast foods and seldom drink soda, juice drinks, sports, or energy drink. 我有節制食用油炸食品或速食和很少喝蘇打水，果汁飲料，運動飲料或能量飲料。	Yes 是	No 否
3	I have gained or lost over 10 lbs. in the last 6 months. 在過去的 6 個月中我的體重增加或減少了 10 磅以上。	Yes 是	No 否
Physical Activity 活動能力			
4	I exercise. 我有運動。	Yes 是	No 否
	If you answered "Yes," please answer the following questions a and b: 如果您對問題的回答為 "是"，請回答以下問題 a 和 b： a. How many days a week do you exercise? □ 1 to 2 days □ 3 to 4 days □ 5 to 7 days 您每週運動幾天？ 一至兩天 三至四天 五至七天 b. How long do you exercise? □ <30 mins □ > 30 mins □ 1 hour □ ≥ 1 hr 你每次運動多長時間？ 30 分鐘以下 30 分鐘以上 一小時 多於一小時		
Continence 尿失禁評估			
5	I have problems with urinating. 我排尿有問題。	Yes 是	No 否
	If you answered "Yes" to question 5, why do you have trouble with urinating? 如答 "是," 原因是什麼: □ Leaking 漏尿 □ Frequent trips 常跑廁所 □ Other 其他_____		
6	I have frequent urinary tract infections (more than 2 times a year). 我常常有尿道感染 (一年超過兩次)。	Yes 是	No 否
7	I have diagnosed with an enlarged prostate. 我被診斷過有攝護腺問題。	Yes 是	No 否
Home and Safety 居家安全			
8	I feel safe where I live. 我的居住環境很安全。	Yes 是	No 否
9	I drive cautiously, always wear a seat belt while sitting in a car and have not had a car accident in the past year. 我開車小心, 每次都有繫安全帶, 並且過去一年都沒有駕駛意外。	Yes 是	No 否

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Fall Risk, Vision, and Hearing Problem 跌倒風險、視力與聽力問題			
10	I have fallen in the past 12 months. 過去一年我有跌倒過。	Yes 是	No 否
	If you answered "Yes" to question 10, please answer the following questions a and b: 如答 "是"，請回答 a 和 b 問題: **a.** How many times did you fall? □ 1 time □ 2 or more times 一年內跌倒幾次? 一次 兩次以上 What caused your fall? 是什麼導致你跌倒:_____ **b.** Did your fall cause a fracture or serious injury? 跌倒是否造成你骨折或嚴重傷害? □ No 沒有受傷 □ Yes. Explain the injury 有, 造成何處受傷:_____		
11	I have safety bars installed in my bathroom. 我的浴室裝有安全把手。	Yes 是	No 否
12	My vision and hearing changed a lot in the past 12 months. 我的視力和聽力在過去 12 個月有很大的變化。	Yes 是	No 否
Oral Health and Lifestyle & Staying Healthy 口腔衛生和生活方式			
13	I have problem with my oral health. 我有口腔或牙齒的問題。	Yes 是	No 否
14	I can chew and swallow easily. 我沒有咀嚼或吞嚥的困難。	Yes 是	No 否
15	I smoke/chew tobacco. 我有抽過煙或嚼煙草。 If Yes, Frequency of Tobacco Use 如答"是," 請列煙草使用頻率 : _____	Yes 是	No 否
16	I drink alcohol. If you answered "Yes," How many glasses do you drink a day? 我有喝酒。如答 "是," 你一天喝幾杯酒? □ < 2 glasses 不超過 2 杯 □ ≥ 2 glasses 超過 2 杯	Yes 是	No 否
17	Have you had the following health vaccinations? 您是否接種過以下健康疫苗? **a.** Flu shot in the last year 去年的流感疫苗 □ Yes 是 □ No 否 □ Do not know or remember 不知道或不記得 □ Not Applicable 不適用 **b.** Pneumonia shot in the last 5 years 過去 5 年的肺炎疫苗 □ Yes 是 □ No 否 □ Do not know or remember 不知道或不記得 □ Not Applicable 不適用 **c.** Covid-19 vaccine 冠狀病毒疫苗 □ Yes 是 □ No 否 □ Do not know or remember 不知道或不記得 □ Not Applicable 不適用		
Functional Status Assessment 日常生活狀態評估			
18	I can take care of my daily living activities: eating, toileting, bathing, dressing, walking, etc. 我可以照顧自己的生活, 包括吃飯、上廁所、洗澡、穿衣、自由行走等。 If you answered "No," please explain 如果不可以, 原因是什麼:_____	Yes 是	No 否
19	I can handle jobs like doing laundry, cooking, using the telephone, driving or taking buses, shopping, etc. 我可以做一般家務包括洗衣、做飯、打電話、開車、搭公車及逛街等。 If you answered "No," please explain 如果不可以, 原因是什麼_____	Yes 是	No 否
20	I have trouble remembering important things such as taking my medications on time. 我有嚴重的記憶問題, 我會忘記按時服用藥物。	Yes 是	No 否

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Pain Scale 疼痛測量 **Location of Pain** 疼痛的位置 **:** _____

Circle the number that best describes pain level in the last five days
圈出最能描述過去五天疼痛程度的數字

21	0	1	2	3	4	5	6	7	8	9	10
Verbal Scale 口頭評分	No Pain 無痛	Mild Pain 輕度疼痛		Moderate Pain 中度疼痛				Severe Pain 嚴重的疼痛			Worst Possible 最壞的可能
	0	1	2	3	4	5	6	7	8	9	10
Activity Scale 活动能力評分	No Pain 無痛	Can be Ignored 可忍受		Interfere with Tasks 干擾到工作		Interferes with Concentration 干擾到注意力		Interferes with Basic Needs 干擾到日常生活			Bed Rest Required 需臥床休息

Advance Directive 醫療指示

22	Have you ever completed an Advance Care Plan? 您有預設醫療指示嗎?	Yes 是	No 否
	If you marked "No," do you want to receive one? 如果沒有, 您想得到有關資料嗎? *Please ask your PCP for materials 請向你家庭醫生索取資料	Yes 是	No 否
23	Do you have other questions or concerns about your health? 您對健康還有其他疑問或疑慮嗎?	Yes 是	No 否
	If Yes, please describe: 如果是，請描述:		

* I understood the above questionnaire and received education and counseling from my Primary Care Physician.
我理解了上述問卷並接受了我的家庭醫師的諮詢。

Office Use Only 以下僅限 (醫師/醫務人員) 使用

	Six Item Cognitive Impairment Test (6CIT)		Score
24	What year is this?	□ Correct (0 pt) □ Incorrect (4pts)	
25	What month is this?	□ Correct (0 pt) □ Incorrect (3pts)	
26	Give the patient an address phrase to remember with 5 components: Example: John Doe, 52 Grand St, Arcadia	Make sure patient can repeat address phrase properly and inform him/her that you will ask to repeat later.	
27	About what time is it (within one hour)?	□ Correct (0 pt) □ Incorrect (3pts)	
28	Count backwards from 20-1.	□ Correct (0 pt) □ 1 Error (2pts) □ > than 1 Error (4 pts)	
29	Say the months of the year in reverse	□ Correct (0 pt) □ 1 Error (2pts) □ > than 1 Error (4 pts)	
30	Repeat address phrase	□ Correct (0 pt) □ 1 Error (2pts) □ 2 Errors (4 pts) □ 3 Errors (6 pts) □ 4 Errors (8pts) □ All wrong (10 pts)	
		(6CIT score) **Add all scores to total**	

0-7 Normal | **8 -9** Mild Cognitive Impairment (consider referral) | **10-28** Significant Cognitive Impairment (referral)

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Depression Screening (PHQ-9) 憂鬱症篩檢調查

	Over the last 2 weeks, how often have you been bothered by any of the following problems? 在過去的 2 個星期, 你有多少次被以下問題困擾?	Not at all 沒有	Several Days 少於 7 天	More Than Half the Days 多於7天	Nearly Every day 幾乎每天
1	Little interest or pleasure in doing things 不管做什麼事都提不起勁來或沒有興趣去做	0	1	2	3
2	Feeling down, depressed, or hopeless 感覺心情低落、憂鬱、或是絕望	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much 無法入睡或保持入眠，或者是睡得太多	0	1	2	3
4	Feeling tired or having little energy 覺得很累或是沒有精神	0	1	2	3
5	Poor appetite or overeating 沒有食慾或是食量大增	0	1	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down 經常覺得愧疚，或是覺得自己拖累了自己或家人	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television 無法集中注意力，如看報紙或看電視時會分心	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual 講話或行動速度變慢，慢到其他人都有注意到。或您變得不安、焦躁並且動得比平常更多	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way 想過要傷害自己，或甚至覺得也許死掉會比較好	0	1	2	3
10	If you circle any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? 如果你圈出了任何問題，這些問題對於繼續你的工作，照顧家裡的事和社交產生了多大的困擾和阻力?	Not difficult at all 完全沒有阻力和困擾 □			
		Somewhat difficult 有一些阻力和困擾 □			
		Very difficult 有很大阻力和困擾 □			
		Extremely difficult 有極大阻力和困擾 □			

1-4 Minimal Depression 5-9 Mild Depression 10-14 Moderate Depression 15-19 Moderately Severe Depression 20-27 Severe Depression	TOTAL 總分:

Provider's Name (Print) / 醫生姓名: _____Title: M.D./D.O.

Provider's Signature / 醫生簽名: _____Reviewed Date: _____

* I have reviewed these questionnaires with my patient and will schedule a follow up as needed.

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