PHYSICIAN PARTNERS
PULMONARY, CRITICAL CARE, SLEEP SPECIALISTS
PATIENT SCREENING AND ASSESSMENT

Date_____ Name: _____DOB _____

If you have had the following vaccines, please document the dates given:

Flu_____ Shingles_____ Pneumovax_____ Prevnar_____

Have you lost interest in doing things that use to give you pleasure?

[ ] Not at all [ ] several days [ ] more than half the days [ ] nearly every day

Have you been feeling down, depressed or hopeless in the past 2 weeks?

[ ] Not at all [ ] several days [ ] more than half the days [ ] nearly every day

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Have you experienced 10 lbs weight loss or weight gain in the past 3 months?

[ ] No [ ] Yes

Do you have problems with mobility (use a wheelchair, cane or walker)?

[ ]No [ ] Yes; describe the problem and/or the device used: _____

Have you had a fall in the past year?

[ ] No [ ] Yes

Do you feel unsteady?

[ ] No [ ] Yes

Are you in a relationship where you are being threatened or hurt?

[ ] No [ ] Yes