Name:

DOB: Date:

Annual Health Risk Assessment **Ideal Medical Care of NY**

Cigarettes Smoking: Smokes... **Never☐**

☐Former. ☐Some days. ☐Every day.

I smoke/smoked _____ cig/day, or ____ pack/day for ___ years.

I quit smoking _____ years back, in year _____.

E-Cigarettes/Vaping: Yes☐, **No☐**

Illegal Drug Use: **Never☐**

☐Yes, I take: ☐Past use: I took:

HIV Risk: Are you ?

☐ sex worker; ☐ I/V drug user or sex partner of I/V drug user

☐>1 sex partner in last 1 year **None of the above☐**

Do you have **smoke alarm** in your house? No☐, **Yes☐**

Car Seat Belt use: Never☐, Sometimes☐, **Always☐**

Do you exercise regularly ? No☐, **Yes☐**

Sensory / Ambulation assessment:

Do you have problem with vision ? Yes☐, **No☐**

Do you have problem with hearing ? Yes☐, **No☐**

Do you have problem with walking ? Yes☐, **No☐**

Do you have? Glasses ☐ Hearing aid ☐ Diapers ☐ **None☐**

Cane ☐ Walker ☐ Wheel chair ☐

Pain Assessment:

Do you have "chronic" pain? Yes☐, **No☐**

Location: _____. Started _____ ☐ months / ☐years back.

Circle the level of pain: [0=No pain. 1=minimal pain. 10=Worst/Extreme pain]

At WORST my pain is at: 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

At BEST my pain is at : 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

I don't feel pain all the time☐

Do you have any **skin** mole/ lump that is **changing or quickly increasing** in size ? Yes☐, **No☐**

Females only: Do you regularly self-examine of breasts and skin? No☐, **Yes☐**

Males only: Do you regularly self-examine of genitals and skin? No☐, **Yes☐**

Do you have: Trouble with erection or sex☐. Wake up at night to urinate☐. Reduced urinary flow☐. Leaks urine☐. Blood in urine☐. **No problem ☐**

Social Connection & Isolation: (NHANES)

☐ Single	☐ Married	☐ Widowed	☐ Separated	☐ Divorced	☐ Has partner

In a typical WEEK: how many times do you call/meet family, friends or neighbors? ☐ More than 3 times per week / ☐ 3 or less times per week

In a typical YEAR: How often do you attend masjid/temple/church/religious events? ☐ More than 4 times per year / ☐ 4 or less times per year

Do you belong to any groups such as: Whatsapp, Facebook, masjid/church/temple groups, unions/ fraternal/ sports/ school groups? Yes☐, **No☐**

Do you feel threatened /abused /humiliated by anyone ? Yes☐, **No☐**

Depression & Anxiety Screening:

		0	1	2	3
	In "last 14 days" how many days were you bothered by :	**Not at all**	**Less than 7 days**	**More than 7 days**	**Nearly every day**
PHQ-2	Having less interest or pleasure in doing things	☐	☐	☐	☐
	Feeling down, depressed or hopeless	☐	☐	☐	☐
GAD-2	Feeling nervous, anxious or on edge	☐	☐	☐	☐
	Not being able to stop or control worrying	☐	☐	☐	☐

Alcohol Use Screening: (AUDIT-C) **☐ NEVER. I don't drink alcohol at all.** (If you don't take any alcohol, you may skip this section)

How often do you have a drink containing alcohol?	Never ☐	Monthly or less☐	2-4 times a month☐	2-3 times a week☐	4 times a week☐
How many standard drinks containing alcohol do you take in a typical day when you drink?	I don't drink ☐ 1 or 2 drinks☐	3 or 4 ☐	5 or 6 ☐	7 or 9 ☐	10 or more ☐
How often do you have six or more drinks on one occasion?	Never ☐	Less than monthly☐	Monthly ☐	Weekly ☐	Almost daily ☐

Name:	Date:

(Functional Assessment Form for age 65 & above)

Fall Screen

Number of falls in last 1 year:	#	None ☐	
Number of falls with injuries:	#	None ☐	
Any detail about the fall:		None ☐	

Do you require assistance with any of the following?" Choose one of the following responses:

	No help needed	**Needs some help from others**	**Totally dependent on others**
Bathing			
Dressing, changing clothes			
Eating from plate			
Using Toilet			
Getting in and out of bed or chair			
Self control over urination and defecation			
Going to places that are out of walking distance			
Food Preparation			
Grocery Shopping			
Housekeeping / Chores			
Money / Finances Management			
Administering own medication			
Ability to use Telephone			
Laundry			

Don't write below this line:

Timed Up and Go Test: (Use standard armchair & allow a trial walk before actual test. Customary walking aid is allowed. No physical assistance is allowed). Rise from the chair · Walk to the line on the floor (10 feet) · Turn · Return to the chair · Sit down again. Grading: =<10 seconds: Low risk / 11-19 sec: Moderate risk />20 sec : High risk. Pt Score: _____

Health Care Proxy

(1) I, (your name) _____

hereby appoint (Name) _____

(name, home address and telephone number)

(Address) _____

(Phone number) _____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____

(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (*Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions):*

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line),* your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Date _____

Name *(print)* Zeeshan Hasan, MD

Signature _____

Address Ideal Medical Care of NY PLLC

2 Arkansas Dr, Valley Stream, NY 11580

Witness 2

Date _____

Name *(print)* _____

Signature _____

Address Ideal Medical Care of NY PLLC

2 Arkansas Dr, Valley Stream, NY 11580

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