ANNUAL QUESTIONNAIRE

Patient Name: _____ Date: _____

Do you have little interest and/or pleasure in doing things? ☐ Yes ☐ No

If YES, Please check one: ☐ Several Days ☐ More than half the days ☐ Everyday

Are you feeling down, depressed or hopeless? ☐ Yes ☐ No

If YES, Please check one: ☐ Several Days ☐ More than half the days ☐ Everyday

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several Days 1	More than Half the days 2	Everyday 3
Do you have trouble falling or staying asleep or sleeping too much?				
Do you feel tired or having little energy?				
Do you have poor appetite or overeating?				
Do you feel bad about yourself, or that you are a failure, or have let yourself or your family down?				
Do you have trouble concentrating on things, such as reading the newspaper or watching television?				
Do you move or speak 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?				
Do you have thoughts that you would be better off dead and/or of hurting yourself in some way?				

Immunizations:

Have you had a Pneumonia Vaccination? ☐ Yes ☐ No If yes, When: _____

Have you had a Flu Vaccination? ☐ Yes ☐ No If yes, When: _____

Have you fallen in the past year (If 65 or older please answer)? ☐ Yes ☐ No

If yes, please complete:

☐ I fell with injury ☐ 2 or more falls with injury

☐ I fell without injury ☐ 2 or more falls without injury