Oak Hill Gynecolgy & Obstetrics ***Quality Form***		
Name:	***DOB:***	***Date:***

Ambulatory Status: Please check ***ALL*** that apply

☐ Independent	☐ Dependent on helper pushing wheelchair
☐ Uses a cane	☐ Confined to chair
☐ Uses motorized scooter	☐ Does not walk
☐ Uses Ambulartory Aid	☐ Unable to walk
☐ Uses a wheelchair	☐ Does not initiate walking
☐ Wheelchair bound	☐ Unable to initiate walking
☐ Independent in wheelchair	☐ Is bedbound (bed-ridden)
☐ Minimal help with wheelchair	

Have you fallen in the past year?

☐ Yes**	☐ No

****If YES, how many time did you fall?**

☐ 0-3	☐ 4 and Over

What were the circumstances surrounding the fall?

☐ Uncontrolled bladder	☐ Environmental Hazard (loose rug/stairs, etc)
☐ Visual impairment	☐ Pain affecting level of function
☐ Difficulty ambulating	☐ Cognitive impairment

Depression Screening:

Have you experienced little interest or pleasure in doing things?

☐ Yes	☐ No

Have you experienced feeling down or hopeless?

☐ Yes	☐ No

Please record the last date/year and place that you had the following:

Shots/Vaccines:

Flu Vaccine	When?	
Pneumonia Vaccine	When?	

Social History Info:

Tobacco Use?	
Alcohol Use?	

Testing:

Last Mammogram	When/Where?	
Last Colonoscopy/FOBT/Sigmoidoscopy (circle which one)	When/Where?	
Pap Smear	When/Where?	

Diabetic Patients ONLY:

Last Dilated/Retinal Eye Exam: (Date)	
Ophthalmologist/Optometrist Name:	

Last Diabetic Foot Exam: (Date)	
Podiatrist Name:	