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| Interval HEALTH HISTORY QUESTIONNAIRe |
| An attempt at a COVID19 Guidelines compliant solution for a face-to-face encounter |
| Name (Last, First, M.I.): |  | 🞎 M 🞎 F | DOB: |  |

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| Current Address:Street: | City:  | State: | Zip: |
| email: |  | Cell: | Home: |  |
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| PREVENTIVE HEALTH HISTORY |
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| Childhood illness: | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio |
| Immunizations and dates: | 🞎 Tetanus |  | 🞎 Pneumonia |  |
| 🞎 Hepatitis A |  | 🞎 Zoster |  |
| 🞎 Hepatitis B |  | 🞎 Influenza |  |
| 🞎 Hepatitis C Screen |  | 🞎 MMR Measles, Mumps, Rubella |  |

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| MEDICATIONS |
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| Date Started | Medication | Dose | Frequency | Reason |
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| Interval medical history |
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| **Health History since your last visit:** |

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| interval DIAGNOSES |
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| Are you basically satisfied with your life? | * Yes No
 |
| Have you dropped many of your activities and interests? | * Yes No
 |
| Do you feel that life is empty?  | * Yes No
 |
| Do you often get bored? | * Yes No
 |
| Are you in good spirits most of the time? | * Yes No
 |
| Are you afraid of something bad is going to happen to you? | * Yes No
 |
| Do you feel happy most of the time? | * Yes No
 |
| Do you often feel helpless? | * Yes No
 |
| Do you prefer to stay home rather than go out and do new things? | * Yes No
 |
| Do you feel you have more problems with memory than most? | * Yes No
 |
| Do you think it is wonderful to be alive now? | * Yes No
 |
| Do you feel pretty worthless the way you are now? | * Yes No
 |
| Do you feel full of energy? | * Yes No
 |
| Do you feel that your situation is hopeless? | * Yes No
 |
| Do you think that most people are better off than you are? | * Yes No
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| **DEPRESSION SCALE**\*For each question, choose yes or no based on your current emotional health |

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| **ICD9** | **Date Dx** | **Diagnosis** | **Supporting Tests/Studies** | **Date(s)** |
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|  **ACTIVITIES OF DAILY LIVING** \*For each task, choose the description that most closely matches your highest function level |

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| **ACTIVITY** | **DESCRIPTION** |
| Using the Restroom | * Care for self in restroom completely; no incontinence
 |
|  | * Needs to be reminded, or needs help in cleaning self, or has rare (weekly at most) accidents
 |
|  | * Soiling or wetting while asleep more than once a week
 |
|  | * Soiling or wetting while awake more than once a week
 |
|  | * No control of bowels or bladder
 |
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| Feeding | * Eats without assistance.
 |
|  | * Eats with minor assistance at meal times and/or with special preparation of food, or help in cleaning up after meals.
 |
|  | * Feeds self with moderate assistance and is untidy.
 |
|  | * Requires extensive assistance for all meals.
 |
|  | * Does not feed self at all and resists efforts of others to feed him or her
 |
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| Dressing  | * Dresses, undresses, and selects clothes from own wardrobe.
 |
|  | * Dresses and undresses self, with minor assistance.
 |
|  | * Needs moderate assistance in dressing and selection of clothes.
 |
|  | * Needs major assistance in dressing, but cooperates with efforts of others to help.
 |
|  | * Completely unable to dress self and resists efforts of others to help.
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| Grooming (neatness, hair, nails, hands, face, clothing) | * Always neatly dressed, well-groomed, without assistance.
 |
|  | * Grooms self adequately with occasional minor assistance, eg, with shaving
 |
|  | * Needs moderate and regular assistance or supervision with grooming
 |
|  | * Needs total grooming care, but can remain well-groomed after help from others
 |
|  | * Actively negates all efforts of others to maintain grooming
 |
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| Physical Ambulation | * Goes about grounds or city
 |
|  | * Ambulates within residence on or about one block distant
 |
|  | * Ambulates with assistance of (check one)
 |
|  |  a ( ) another person, b ( ) railing, c ( ) cane, d ( ) walker, e ( ) wheelchair |
|  |  1.\_\_Gets in and out without help. 2.\_\_Needs help getting in and out |
|  | * Sits unsupported in chair or wheelchair, but cannot propel self without help
 |
|  | * Bedridden more than half the time
 |
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| Bathing | * Bathes self (tub, shower, sponge bath) without help.
 |
|  | * Bathes self with help getting in and out of tub.
 |
|  | * Washes face and hands only, but cannot bathe rest of body
 |
|  | * Does not wash self, but is cooperative with those who bathe him or her.
 |
|  | * Does not try to wash self and resists efforts to keep him or her clean.
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| **INSTRUMENTAL ACTIVITIES OF DAILY LIVING** \*For each task, choose the description that most closely matches your highest function level |

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| **ACTIVITY** | **DESCRIPTION** |
| Ability to Use Telephone | * Operates telephone on own initiative; looks up and dials numbers.
 |
|  | * Dials a few well-known numbers.
 |
|  | * Answers telephone, but does not dial.
 |
|  | * Does not use telephone at all.
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| Shopping | * Takes care of all shopping needs independently.
 |
|  | * Shops independently for small purchases.
 |
|  | * Needs to be accompanied on any shopping trip.
 |
|  | * Completely unable to shop.
 |
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| Food Preparation | * Plan, prepares, and serves adequate meals independently.
 |
|  | * Prepares adequate meals if supplied with ingredients.
 |
|  | * Heats and serves prepared meals or prepares meals, but does not maintain adequate diet.
 |
|  | * Needs to have meals prepared and served.
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| Housekeeping | * Maintains house alone or with occasional assistance (eg, Heavy-work domestic help).
 |
|  | * Performs light daily tasks such as dishwashing and bed making.
 |
|  | * Performs light daily tasks, but cannot maintain acceptable level of cleanliness.
 |
|  | * Needs help with all home maintenance tasks.
 |
|  | * Does not participate in any housekeeping tasks.
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| Laundry | * Does personal laundry completely.
 |
|  | * Launders small items; rinses socks, stockings, etc.
 |
|  | * All laundry must be done by others.
 |
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| Mode of Transportation | * Travels independently on public transportation or drives own car.
 |
|  | * Arranges own travel via taxi, but does not otherwise use public transportation.
 |
|  | * Travels on public transportation when assisted or accompanied by another.
 |
|  | * Travel limited to taxi or automobile with assistance of another.
 |
|  | * Does not travel at all.
 |
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| Responsibility for Own Medications | * Is responsible for taking medication in correct dosages at correct time.
 |
|  | * Takes responsibility if medication is prepared in advance in separate dosages.
 |
|  | * Is not capable of dispensing own medication.
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| Ability to Handle Finances | * Manages financial matters independently (budgets, writes checks, pays rents and bills, goes to bank); collects and keeps track of income.
 |
|  | * Manages day-to-day purchase, but needs help with banking, major purchases, budgeting, etc.
 |
|  | * Cannot independently manage finances.
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|  **rpow spectacle request prescription form** |
| An attempt at a COVID19 Guidelines compliant solution for a face-to-face encounter |
| **PATIENT INFORMATION** |
| **Name** *(Last, First, M.I.):* |  |

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| **Social Security Number (required):**  |
| **Phone #:**  |
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| **GLASSES PRESCRIPTION** *(COMPLETED BY EYE CARE PROFESSIONAL)* |
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| **Pupil distance:****Bilateral OU** | **Mm:** | **Date of exam and Rx:** |

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|  | **SPH** | **CYL** | **Axis** | **PRISM** | **ADD** | **Eye care professional signature & stamp:** |
| **OD:** |  |  |  |  |  |
| **OS:** |  |  |  |  |  |

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| **GLASSES FRAME SIZE** |



Lens and bridge width (in millimeters)

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**Instruction:**

1. Fill out the form completely (including FULL social security number)
2. Have your local eye care provider complete the “Glasses Prescription” section.
3. Circle your preferred temple and color, “SKULL” or “BAYONET” “GOLD” or “SILVER”.
4. Return this form by either email or mail
5. Scan and email to sydni.m.bates.mil@mail.mil

(In the email subject line, please type: “RPOW Glasses Order”)

1. Mail to:

ATTN: RPOW

340 HULSE ROAD

PENSACOLA, FL 32508

For questions about this form, contact the NAMI/RPOW dept. at 850-452-3099 or 850-452-3149

**CIRCLE PPERFERRED COLOR: SILVER/GOLD**

 **CIRCLE YOUR PERFERRED TEMPLE:**

