

Meaningful Use Questionnaire

Patient Name:	YES	NO
Flu shot in the last 12 months? If yes, what was the MONTH/YEAR		
Pneumonia shot in the last 5 years? If yes, what was MONTH/YEAR		
How many times have you fallen in the past year?		
Were you Injured with your fall?		
Are you a current smoker?		
Did you get Covid vaccine? (if yes see below)		

Please check:	PFIZER	MODERNA	J&J	Date Dose #1:	Date Dose #2:
Over the last 2 weeks, how often have you been bothered by any of the following problems? Use "X" to indicate your answer.					
	Not at all	Several days	More than half the days	Nearly every day	
1) Have you lost interest or pleasure in doing things					
2) Do you feel down, depressed, or hopeless					
3) Trouble falling or staying asleep, or sleeping too much					
4) Feel tired or have little energy					
5) Poor appetite or overeating					
6) Feeling bad about yourself or that you are a failure, or have let yourself or your family down					
7) Trouble concentrating on things, such as reading the newspaper or watching television					
8) Move or speaking 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					
9) Thoughts that you would be better off dead or of hurting yourself in some way					

OFFICE USE ONLY

BMI 65+ yrs-more than 23 less than 30 18-64 yrs-more than 18.8 less than 25
 New BP 120/94 - 4 week follow up
PATIENT EDUCATION-ORDER SETS