What’s on your mind today? Please mark any of the following items you would like to talk about with your physician.

NAME

HEALTH AND WELL-BEING
Please circle the items below you would like to discuss:

- Medications
- Screenings and tests
- Diabetics
- Vaccinations
- Other

HEALTH DISCUSSIONS
Please tell your physician if you are having problems with any of these:
- Urine leakage / bladder control
- Balance problems or falling

HEALTHY LIVING
To help keep myself healthy, I would like to work on:

- Exercise
- Diet and healthy eating
- Weight loss
- Coping with stress
- Reducing unhealthy habits
- Taking medicine correctly

PATIENT HEALTH QUESTIONNAIRE
Over the past four weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things:
- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling down, depressed or hopeless:
- Not at all
- Several days
- More than half the days
- Nearly every day

PHYSICAL HEALTH
Over the past four weeks, how often have you had problems completing your daily activities as a result of your physical health?

Difficulty completing daily activities:
- Not at all
- Several days
- More than half the days
- Nearly every day