**Empirical Risk Management**

Date: \_\_\_\_\_\_\_\_ Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Over the last 2 weeks, how often have you been bothered by any of the following:** | **Not at all**  **(0)** | **Several Days (1)** | **More than ½ the days (2)** | **Nearly every day (3)** |
| Little interest or pleasure in doing things? |  |  |  |  |
| Feeling down, depressed, or hopeless? |  |  |  |  |
| Thoughts that you would be better off dead? |  |  |  |  |
| Trouble falling or staying asleep or sleeping too much? |  |  |  |  |
| Feeling tired or having little energy? |  |  |  |  |
| Poor appetite or overeating? |  |  |  |  |

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| **Functional Ability / Safety Screen** | **Yes** | **No** |
| Because of a health or memory problem do you have any difficulty with bathing or showering? |  |  |
| Because of a health or memory problem do you have any difficulty with managing your money – such as paying your bills and keeping track of expenses? |  |  |
| Because of a health or memory problem do you have any difficulty dressing yourself? |  |  |
| Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry or medications? |  |  |
| Are emergency numbers kept by the phone and regularly updated? |  |  |
| Are all household members aware of the dangers of smoking, especially in bed? |  |  |
| Are working smoke alarms and fire extinguishers available for use? |  |  |
| Have throw rugs been removed or fastened down? |  |  |
| Are non slip mats in all bathtubs and showers? |  |  |
| Do all stairways have a railing or banister? |  |  |

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| **Alcohol Use Screen** | | | | |
| 1. How often did you have a drink containing alcohol in the past year?  a. Never  b. Monthly or less  c. 2 to 4times per month  d. 2 to 3 times per week  e. 4 or more times a week  2. How many drinks did you have on a typical day when you were drinking in the past year?  a. 1 or 2 b. 3 or 4 c. 5 or 6 d. 7 to 9 e. 10 or more  3. How often did you have five or more drinks on one occasion in the past year?  a. Never b. Less than monthly c. Monthly d. Weekly e. Daily or almost daily? | | | | |
| * **Scoring - a = 0, b = 1, c= 2, d = 3, e = 4** * **For a male, score over 4 is positive** * **For a female, score over 3 is positive** | | | | |
| **HHIE-S** | **Yes**  **(4 pts)** | **Sometimes**  **(2 pts)** | **No**  **(0 pts)** |
| Does a hearing problem cause you to feel embarrassed when you meet new people? |  |  |  |
| Does a hearing problem cause you to feel frustrated when talking to members of your family? |  |  |  |
| Do you have difficulty hearing when someone speaks in a whisper? |  |  |  |
| Do you feel handicapped by a hearing problem |  |  |  |
| Does a hearing problem cause you difficulty when visiting with friends, relatives, or neighbors? |  |  |  |
| Does a hearing problem cause you to attend religious services less often than you would like? |  |  |  |
| Does a hearing problem cause you to have arguments with family members? |  |  |  |
| Does a hearing problem cause you difficulty when listening to TV or radio? |  |  |  |
| Do you feel that any difficulty with your hearing limits or hampers your personal or social life? |  |  |  |
| Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? |  |  |  |
| **TOTAL POINTS** |  | | |
| 0-8 – No hearing impairment  10 to 24 – 50% probability of hearing impairment  26 to 40 – 84% probability of hearing impairment | **Referral for Audiology Exam**  **Yes or NO** | | |

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| **List the all the doctors and specialists that you are seeing** |

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| Do you use tobacco?   * **If you smoke, You should stop. Smoking increases risk of death, heart attack, stroke and cancers.** | Yes | No |
| Do you drink caffeine? | Yes | No |
| Occupation How many hours a week do you work? | | |
| What kind of exercise do you do?  How Often? | | |
| Do you have an Advance Directive? | Yes | No |
| Do you have any allergies?  If so, please list | Yes | No |

**Physicicans Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_**