
Hello.

There are some questions I need to ask to help plan care for you or your family member.

I have each question written for you. We will give you answer choices for most questions. Please point to the answer or write an answer so we can start to plan your care. If you are not sure about a question or how to answer the question, please point to “Not sure” on the sheet.

Can you tell me your name?

No

Not sure

Yes



Can you write your name on this paper for me?

No

Not sure

Yes



Did you come here alone?

No

Not sure

Yes



Do you have other family members or friends with you?

No

Not sure

Yes



**If yes, can you tell me or write their names
and ages?**

No

Not sure

Yes



Are any of your family members pregnant?

No

Not sure

Yes



**Has anyone in your family been hospitalized
that you know of?**

No

Not sure

Yes



Is anyone in your family deceased that you know of?

No

Not sure

Yes



Are you the person that needs help with care?

No

Not sure

Yes



If not, please write their name.

Not sure

How are you related to this person?

- Parent
 - Guardian
 - Spouse
 - Child
 - Brother or sister
 - Partner
 - Other family member
 - Friend or neighbor
 - No relationship
-

The next questions are about the person who needs care. If you are giving answers for that person, please be sure the **answers are about that person.**

For example, if you are answering for your child and the question is “age”, you would give the age of your child needing care, not your age.

Age

Please tell me or write the number.

Not sure

What race are you?

Please tell me or write it down.

Not sure

Address

Please tell me or show me something with the address, or write the address.

Not sure

**Do you have a medical or health concern
right now?**

No

Not sure

Yes



How are you feeling physically?



0

Fine



2



4



6



8



10

Very Ill

Not Sure

Can you point to the part of the body where you have pain?

No

Not sure

Yes



If yes, please show me.

Some people have mental distress such as sadness, confusion or anger. How much mental distress do you have right now?



0

None



2



4



6



8



10

Very much

Are you in danger of hurting yourself or someone else right now?

No

Not sure

Yes



Do you need any medicine, equipment or other items for daily living?

No

Not sure

Yes



Do you need a caregiver or do you have a personal assistant?

No

Not sure

Yes



Is your caregiver here and planning to stay with you?

No

Not sure

Yes



Your caregiver's name:

Please tell me or write the name.

Not Sure

Do you have a service animal?

No

Not sure

Yes



Is the service animal with you?

No

Not sure

Yes



If no, do you know where the animal is?

No

Not sure

Yes



Are you receiving any Medicare or Medicaid benefits?

No

Not sure

Yes



Do you have your card with you?

No

Not sure

Yes



Do you have any allergies to foods, medicine or things around you?




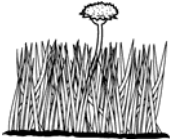
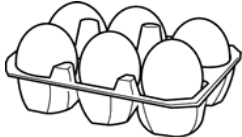

No

Not sure

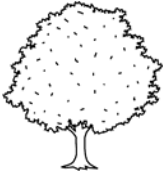
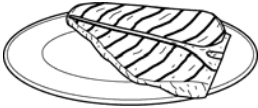

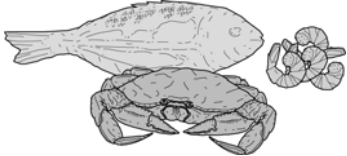
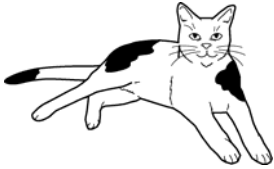

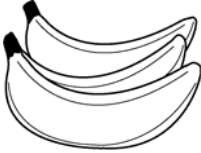
Yes



Tell me what you are allergic to from this list.

<input type="checkbox"/> Mold	<input type="checkbox"/> Nuts or peanut butter 
<input type="checkbox"/> Latex 	<input type="checkbox"/> Milk 
<input type="checkbox"/> Grass 	<input type="checkbox"/> Eggs 
<input type="checkbox"/> Tape 	<input type="checkbox"/> Wheat or gluten

Tell me what you are allergic to from this list.

<input type="checkbox"/> Tree pollen 	<input type="checkbox"/> Beef 
<input type="checkbox"/> Dust 	<input type="checkbox"/> Fish or shellfish 
<input type="checkbox"/> Animal hair 	<input type="checkbox"/> Mushrooms 
<input type="checkbox"/> Bananas 	<input type="checkbox"/> Other things not on this list <input type="checkbox"/> Not sure



If medicine, what type?

- Penicillin
 - Sulfa
 - Aspirin
 - Iodine
 - Others not on this list
 - Not sure
-

Do you have or wear any kind of medical identification?

No

Not sure

Yes



If yes, please show me.

**Have you been in the hospital or at a clinic or
under the care of a doctor in the past month?**

No

Not sure

Yes



If yes, what for?

- Check up
 - To get medicine
 - For tests
 - For heart problems
 - For pain
 - For stomach problems
 - For surgery
 - For high blood pressure
 - Other reason
 - Not sure
-

Can you tell me which hospital or clinic?

- Riverside Methodist Hospital
 - Grant Medical Center
 - Doctors Hospital
 - Grady Memorial Hospital
 - Dublin Methodist Hospital
 - Mount Carmel East
 - Mount Carmel West
-

Can you tell me which hospital or clinic?

- Mount Carmel St. Ann's
 - Mount Carmel New Albany Surgical Hospital
 - Ohio State University Hospital
 - Ohio State University Hospital East
 - Ohio State's James Cancer Hospital and
Solove Research Institute
 - Ohio State's Richard M. Ross Heart Hospital
-

Can you tell me which hospital or clinic?

- Ohio State's Harding Hospital
 - Ohio State University Prime Care Network
 - Nationwide Children's Hospital
 - Neighborhood health center
 - Other clinic or hospital
 - Not sure
-

Can you tell me the name of the doctor?

Please tell me the name, show me the name from a card, or write the name.

Not Sure

Do you have a condition that requires any special medical equipment or supplies?

No

Not sure

Yes

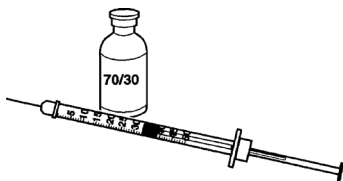


If yes, can you tell me what you use?

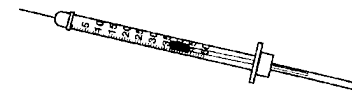
Epinephrine pen for allergy



Insulin



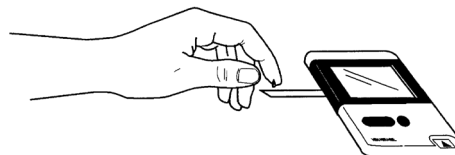
Syringes



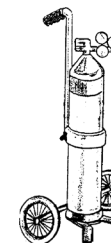
Nebulizer



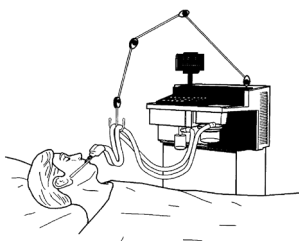
Glucose meter



Oxygen



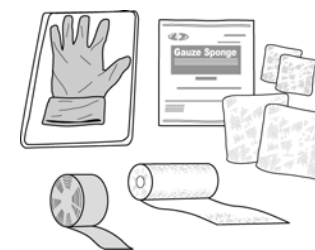
Respirator



CPAP

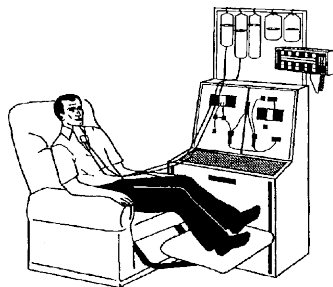


Dressings

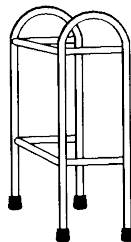


If yes, can you tell me what you use?

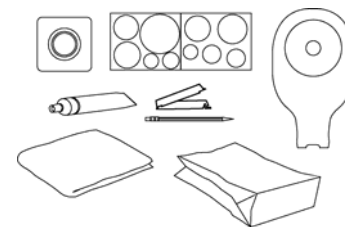
Dialysis



Walker



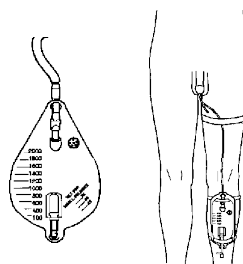
Ostomy supplies



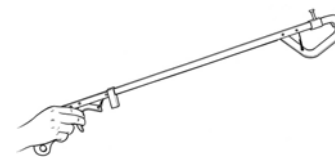
Tube feedings



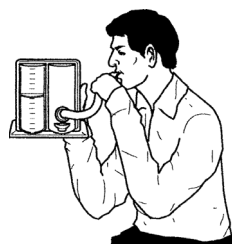
Foley catheter



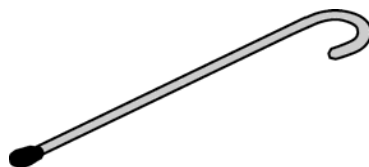
Reacher



Incentive spirometer



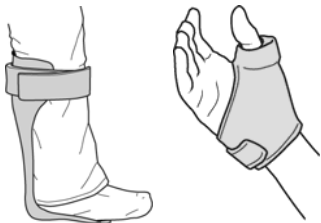
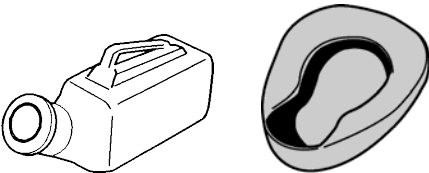
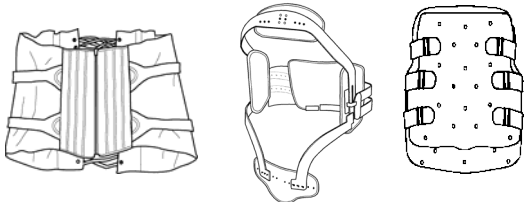

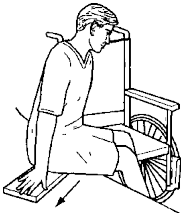

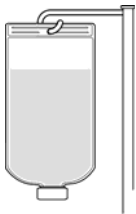
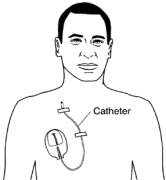
Cane



Sock aid



If yes, can you tell me what you use?

<input type="checkbox"/> Splint 	<input type="checkbox"/> Urinal or bed pan 	<input type="checkbox"/> Brace 
<input type="checkbox"/> Wheelchair 	<input type="checkbox"/> Transfer board 	<input type="checkbox"/> Raised toilet seat 
<input type="checkbox"/> Parenteral nutrition 	<input type="checkbox"/> Port or catheter for medicines 	<input type="checkbox"/> Other supplies not on this list <input type="checkbox"/> Not sure

Did you bring any of these supplies with you?

No

Not sure

Yes



Do you take any medicines every day?

No

Not sure

Yes



Do you have your medicine with you?

No

Not sure

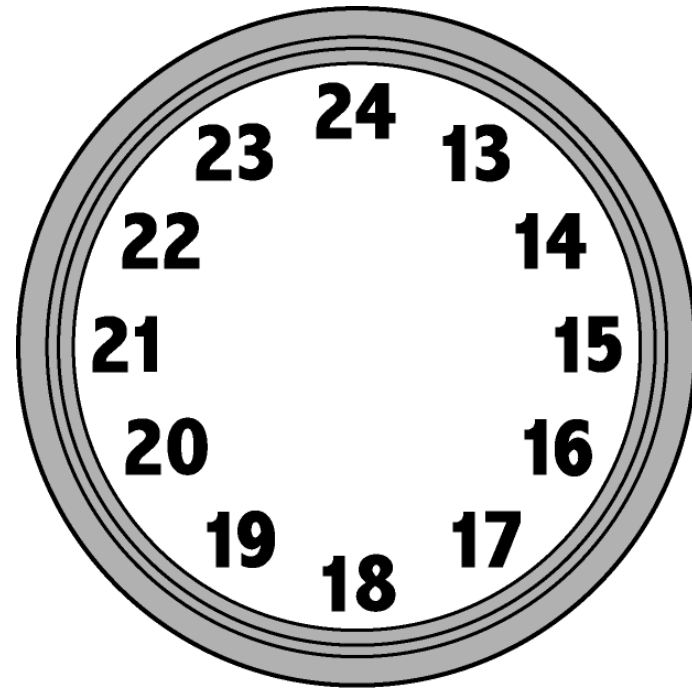
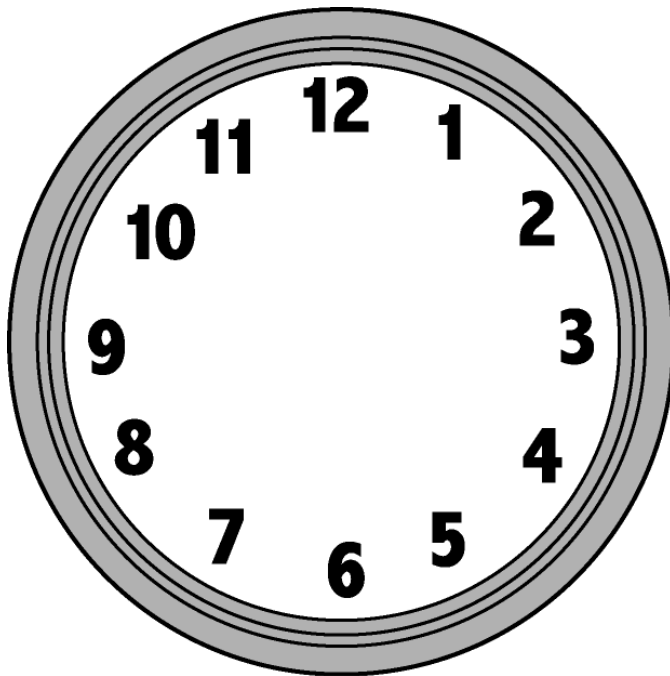
Yes



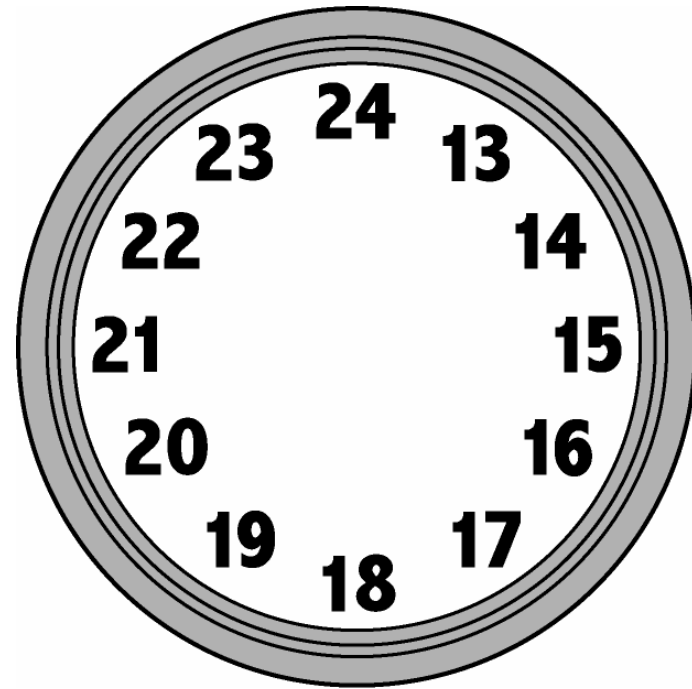
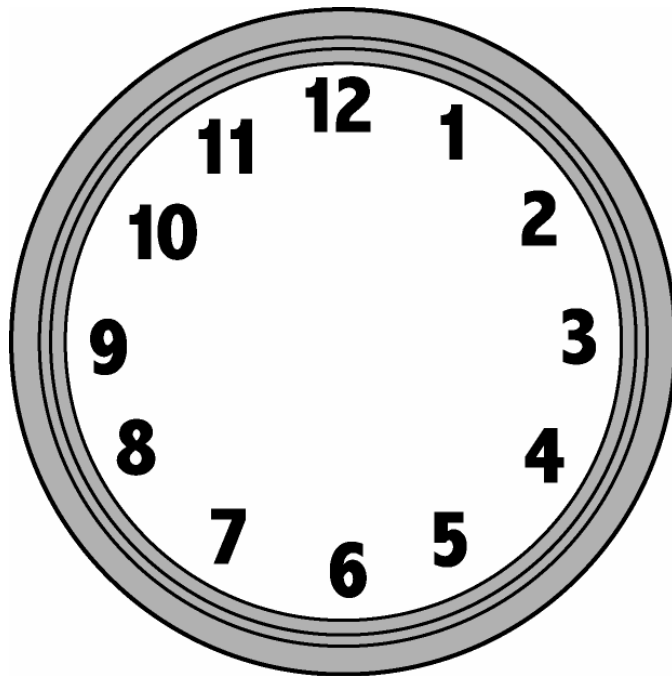
When did you last take this medicine?

- Today
 - Yesterday
 - More than 2 days ago
 - More than a week ago
 - Not sure
-

What time did you take it?



When should you take your medicine again?



Do you know the name of the place where you get your medicines (such as a drug store, pharmacy, grocery store or clinic)?

No

Not sure

Yes



Do you know the names of the medicines you take?

No

Not sure

Yes



Do you know what you take medicine for?

- Heart problems
 - High blood pressure
 - Diabetes
 - Kidney problems
 - Liver problems
 - To thin my blood
 - To lower cholesterol
 - To control my stress
 - To help me sleep
 - Cancer
-

Do you know what you take medicine for?

- Pain control
 - Arthritis
 - To help my circulation
 - Allergies
 - To treat an infection
 - HIV or AIDS
 - Anemia
 - Eye problems
 - Breathing problems
 - Skin problems
-

Do you know what you take medicine for?

- To help my memory
 - Thyroid problems
 - To help me get
rid of fluid
 - Tuberculosis
 - Malaria
 - Muscle spasms
 - Other reasons not
on this list
 - Not sure
-

Do you have any problems with your hearing?

No

Not sure

Yes



Do you use a hearing aid?

No

Not sure

Yes



Do you have your hearing aid with you?

No

Not sure

Yes



Is your hearing aid working?

No

Not sure

Yes



Do you need a battery?

No

Not sure

Yes



Do you need a sign language interpreter?

No

Not sure

Yes



How do you best communicate with others?

- Sign language
 - Lip read
 - Use a TTY
 - Write notes
 - Use communication board
 - Not sure
-

Do you wear prescription eye glasses?

No

Not sure

Yes



Do you have your glasses with you or with your belongings?

No

Not sure

Yes



Do you have problems seeing, even with your glasses?

No

Not sure

Yes



Do you use a white cane?

No

Not sure

Yes



Do you have your white cane with you?

No

Not sure

Yes



Do you need help getting around, even with your white cane?

No

Not sure

Yes



Do you need help moving around?

No

Not sure

Yes



Do you need help getting in or out of bed?

No

Not sure

Yes



Do you need help getting dressed?

No

Not sure

Yes



Do you need help using the bathroom?

No

Not sure

Yes



Do you need help bathing?

No

Not sure

Yes



Do you need help eating?

No

Not sure

Yes



Do you need help cutting up your food?

No

Not sure

Yes



Do you have a family member, friend or caregiver with you to help you with these activities?

No

Not sure

Yes



Do you have false teeth or dentures?

No

Not sure

Yes



Do you have your false teeth with you?

No

Not sure

Yes



Are you on any special diet?

No

Not sure

Yes



What type of special diet?

- Diabetes
 - Low salt
 - Renal diet
 - Gluten free diet
 - Vegetarian
 - Kosher
-

What type of special diet?

- Soft foods
 - Diet for problems with swallowing
 - Diet to protect me from infection
 - Other type not on this list
 - Not sure
-

Telephone number where you can be reached?

Another telephone number, if you have one.

Email address, if you have one.

Date of birth
