KANSAS GASTROENTEROLOGY

3121 N. Webb Rd., Suite 101, Wichita, KS 67226-8119
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Date: _____

Patient Name: _____ Date of Birth: _____ Physician: _____

Your overall health is very important to us. The following assists us in providing quality care and will be sent to your Primary Care Physician for follow up care if needed.

1. Have you experienced a fall in the last year? ☐ Yes ☐ No

   1a. If yes, Have you experienced 2 or more falls? ☐ Yes ☐ No

   1b. Have you experienced a major injury caused by a fall? ☐ Yes ☐ No

2. Here are some questions about your health and feelings. Please read each question carefully and check (✓) your best answer. You should answer the questions in your own way. There are no right or wrong answers.

	Yes, describes me exactly		Somewhat describes me		No, doesn't describe me at all	
2a. I give up too easily	_____	2	_____	1	_____	0
2b. I have difficulty concentrating	_____	2	_____	1	_____	0
2c. I am comfortable being around people	_____	0	_____	1	_____	2

During the *past week* , how much trouble have you had with:

	None		Some		A Lot	
2d. Sleeping	_____	0	_____	1	_____	2
2e. Getting tired easily	_____	0	_____	1	_____	2
2f. Feeling depressed or sad	_____	0	_____	1	_____	2
2g. Nervousness	_____	0	_____	1	_____	2

HOW TO SCORE:

1. Add the scores next to each of the blanks you checked. _____
2. If your total score is 5 or greater, then your symptoms of anxiety and/or depression may be excessive.

Above question is from the Duke Anxiety-Depression Scale (DUKE-AD)

3. The following are preventative screenings and measures that are important to your health. Indicate the date you have received the following:

mammogram *(women only)*	Influenza (flu) vaccine	Pneumonia vaccine
_____ Date	_____ Date	_____ Date

Please list below the name of your current Primary Care Physician (Family doctor)

_____