Comprehensive Internal Medicine

Jacqueline T Pearson, MD, MS Carol Hector, MD Ryan Bozof, MD Sumera Pervaiz, MD Arezou Fatemi, MD
Laurae Carpenetti, MD Sudeshna Nandi, MD
Board Certified, Diplomates of the American Board of Internal Medicine
Petula Gunn, NP
Certified Nurse Practitioner

Geriatric Depression Screening

Patient's Name:_____ **Date:**_____

Instructions: Choose the best answer for how you felt over the past week.

Section A	Yes	No
Are you basically satisfied with your life?		
Are you hopeful about the future?		
Are you in good spirits most of the time?		
Do you feel happy most of the time?		
Do you think it is wonderful to be alive now?		
Do you find life very exciting?		
Do you feel full of energy?		
Do you enjoy getting up in the morning?		
Is it easy for you to make decisions?		
Is your mind as clear as it used to be?		
Total Section A		
Section B	**Yes**	**No**
Have you dropped many of your activities and interest?		
Do you feel that your life is empty?		
Do you often get bored?		
Are you bothered by thoughts that you can't get out of your head?		
Are you afraid that something bad is going to happen to you?		
Do you often feel helpless?		
Do you often get restless and fidgety?		
Do you prefer to stay home rather than go out and do things?		
Do you frequently worry about the future?		
Do you feel you have more problems with memory than most?		
Do you feel downhearted and blue?		
Do you feel pretty worthless the way you are now?		
Do you worry a lot about the past?		
Is it hard for you to get started with a new project?		
Do you feel that your situation is hopeless?		
Do you think that most people are better off than you?		
Do you frequently get upset about little things?		
Do you frequently feel like crying?		
Do you have trouble concentrating?		
Do you prefer to avoid social gatherings?		
Total – Section B		
Total A & B		

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Annual Medicare Wellness Visit

Patient's Name: _____ **Date:** _____

In compliance with Medicare guidelines, please list all doctors that you are under care with:

Doctor's Name: _____

Specialty: _____

Location: _____

Phone Number: _____

Doctor's Name: _____

Specialty: _____

Location: _____

Phone Number: _____

Doctor's Name: _____

Specialty: _____

Location: _____

Phone Number: _____

Doctor's Name: _____

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