Yes No ?Vitals

MEDICATIONS

(Including non-prescription medications and vitamins/minerals)

Client Name: Last	First	MSSP ID#_____ Age:_____ Male Female

Date	Medication	Dosage	#Freq. RX	Doctor	Covered by MediCal Yes/No

(Optional) Sent for Review to Doctor(s): _____ Date: _____

a) **In the past 3 months, have you fallen?** _____Yes* _____No

b**) Have you felt dizzy or light headed in the past week?** _____Yes* _____No
*If yes to a) or b), take blood pressure in 2 positions; otherwise, record BP in one position

c) **Confusion:** Yes _____ No ____

d) **Blood Pressure**: Lying _____/_____ Sitting _____/_____ Standing_____/_____

e) **Pulse**:_____

Care Manager:_____ **RN**_____ **SW**_____ **PCM**_____

Type of visit: Initial_____ 6 Month_____ Reassessment_____ Follow-Up_____

Date:_____