Crowley Primary Care, LLC
1325 Wright Avenue Suite A
Crowley, LA 70526
PH: 337 783-4043

My Shared Care Plan

Date: _____

Patient's Name: _____

Date of Birth: _____

Primary Care Physician Name: _____

Primary Care Physician 24 hour phone number: 337-783-4043

Patient's care giver: Does anyone assist you with your medical needs? **CIRCLE ONE: YES/NO**
If yes, Caregiver Name: _____ Phone Number:_____

Please list any other family/friends that assist you with your medical needs and all physicians that you are being followed by

Name	Relationship	Contact Number	They help take care of my:

Physician's Name	What are you seeing this doctor for?	Date of next appointment if you know

Communication Preferences:

The language I am most comfortable speaking is: _____
I like to communicate about my health and important things by: Choose one

☐ Telephone ☐ Email
☐ Text message ☐ Regular post office mail

Patient's Name:_____ DOB: _____

I am allergic to: _____

My Medical problems (Please list all medical conditions that you have. What do you take your medications for? Example: High blood pressure, high cholesterol, depression, anxiety, COPD, etc)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please list any surgeries that you have had within the last 2 years

1.	5.
2.	6.
3.	7.
4.	8.

Medications: Please list any medications that were prescribed by another physician or that you have not informed our office about:

Medication	Dosage/Strength	How often I take	Why I take this medication	Who gave me this medication

Preventive Care: When was the last time you had the following:

- Flu Vaccine: _____
- Pneumonia Vaccine: _____
- Mammogram (females only): _____
- PSA (males only):_____

FOR DIABETIC PATIENT'S ONLY. When was the last time you had the following:

- Foot Exam: _____
- Eye Exam: _____

Do you have an Advanced Directive also known as a Living Will? Circle One: **YES/NO**
Would you like information about Advanced Directive/Living Will? Circle One: **YES/NO**

Geriatric Depression Scale (Short Form)

Patient's Name: _____ Date: _____

Instructions: Choose the best answer for how you felt over the past week. Note: when asking the patient to complete the form, provide the self-rated form (included on the following page).

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / ***NO***	
2.	Have you dropped many of your activities and interests?	***YES*** / NO	
3.	Do you feel that your life is empty?	***YES*** / NO	
4.	Do you often get bored?	***YES*** / NO	
5.	Are you in good spirits most of the time?	YES / ***NO***	
6.	Are you afraid that something bad is going to happen to you?	***YES*** / NO	
7.	Do you feel happy most of the time?	YES / ***NO***	
8.	Do you often feel helpless?	***YES*** / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	***YES*** / NO	
10.	Do you feel you have more problems with memory than most people?	***YES*** / NO	
11.	Do you think it is wonderful to be alive?	YES / ***NO***	
12.	Do you feel pretty worthless the way you are now?	***YES*** / NO	
13.	Do you feel full of energy?	YES / ***NO***	
14.	Do you feel that your situation is hopeless?	***YES*** / NO	
15.	Do you think that most people are better off than you are?	***YES*** / NO	
		TOTAL	

(Sheikh & Yesavage, 1986)