

Supplementary Medical screening program for the Age of 66

First name		Residenti al ID No.	Tel. No.	Home	
Given name				Cell phone	
<input type="checkbox"/> health insurance		<input type="checkbox"/> medicaid recipient		E-mail address	
current address				post code	-

※ Do you agree to receive health information or notices from the NHIC (National Health Insurance Cooperation), KCDC (Korea Centers for Disease Control and Prevention), NCC(National Center for Cancer), and/or health centers by letters or e-mail? (please check) Yes No

※ These are questions about inoculations.

1. Do you receive inoculations with influenza vaccine every year?

① Yes ② No

※ These are questions about your capabilities on daily routines.

2. Please complete the following questions about your present condition by ticking the appropriate box..

2-1. If someone set the table for your meal, you can eat by yourself without any help.

① Yes ② No

2-2. Can you put on your clothes without any help?

① Yes ② No

2-3. Can you go to the toilet by yourself ?

① Yes ② No

2-4. When you take a bath or a shower, can you wash by yourself?

① Yes ② No

2-5. Can you prepare your meals?

① Yes ② No

2-6. Can you go to the places in a walking distance such as a store, clinic, neighbor, or any public offices by yourself without any help?

① Yes ② No

※ These are questions about affective status.

3. Please complete the following questions about your present condition by ticking the appropriate box.

3-1. Have you become less active and have little will to do anything lately?

① Yes ② No

3-2. Do you feel you are useless?

① Yes ② No

3-3. Do you feel that your future is hopeless?

① Yes ② No

※ These are questions about fall Injury and Urinary function.

4. About fall injury: Have you fell down during the last 6 months?

① Yes ② No

5. Urinary function: Do you have any difficulty in urinating or a trouble of holding your urine?

① Yes ② No