ANNUAL WELLNESS VISIT QUESTIONAIRE

***NAME*____ *D.O.B.*______/_________/___________**

TODAY'S DATE _______/_______/____________

SPECIALITY PROVIDERS: List all physicians you are currently seeing or known to

ALLERGY___________________________ ONCOLOGY (CANCER) ___________________________

CARDIOLOGIST (HEART)___________________________ OPTHALMOLOGY (EYE) ___________________________

DERMATOLOGY (SKIN)___________________________ PHYSICAL THERAPY ___________________________

GASTROENTEROLOGY (STOMACH/ LIVER) ____

PODIATRY (FOOT) ___________________________ PAIN ___________________________

ENT (HEAD, NECK, EAR) ___________________________ PULMONOLOGY (LUNGS) ___________________________

ENDOCRINOLOGY (DIABETES, THYROID) ____

NEPHROLOGY (KIDNEY) ___________________________ RHEUMATOLOGY ___________________________

NEUROLOGY ___________________________ UROLOGY (BLADDER)___________________________

OB/GYN ___________________________ OTHER ___________________________

LIST ANY OVERNIGHT HOSPITALS STAYS or SURGERIES OVER THE PAST YEAR

DATE	**REASON**	**LOCATION**

*1.*____

*2.*____

*3.*____

*4.*____

*5.*____

*6.*____

FUNCTIONAL SCREENINGS

1. Do you need help preparing your meals or feeding yourself? ☐Yes ☐No
2. Do you need help getting to the toilet, bathing, or showering? ☐Yes ☐No
3. Do you need help getting dressed? ☐Yes ☐No
4. Do you need help getting from the bed to a chair or climbing stairs? ☐Yes ☐No
5. Do you need help walking across a room? ☐Yes ☐No
6. Do you use a cane, walker or wheelchair? ☐Yes ☐No
7. Do you need help using the telephone? ☐Yes ☐No
8. Do you need help shopping or managing your money? ☐Yes ☐No
9. Do you need help with transportation? ☐Yes ☐No
10. Have you fallen in the past year? ☐Yes ☐No If yes, were you injured ___________________________

ANNUAL WELLNESS VISIT QUESTIONAIRE

***NAME*____ *D.O.B.*______/_________/___________**

DEPRESSION SCREENING (PHQ-9): OVER THE PAST TWO WEEKS HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?

CIRCLE YOUR ANSWER TO EACH QUESTION	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
LITTLE INTEREST OR PLEASURE IN DOING THINGS	0	1	2	3
FEELING, DOWN, DEPRESSED, OR HOPELESS	0	1	2	3
TROUBLE FALLING ASLEEP, STAYING ASLEEP, OR SLEEPING TO MUCH	0	1	2	3
FEELING TIRED OR HAVING LITTLE ENERGY	0	1	2	3
POOR APPETITE OR OVEREATING	0	1	2	3
FEELING BAD ABOUT YOURSELF OR LIKE YOU'RE A FAILURE OR HAVE LET YOURSELF OR YOUR FAMILY DOWN	0	1	2	3
TROUBLE CONCENTRATING ON THINGS SUCH AS READING THE NEWSPAPER OR WATCHING TV	0	1	2	3
MOVING OR SPEAKING SO SLOWLY THAT OTHER PEOPLE COULD HAVE NOTICED? OR OPPOSITE—BEING FIDGETYOR RESTLESS THAT YOU HAVE BEEN MOVING AROUND A LOT MORE THAN USUAL	0	1	2	3
THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD OR OF HURTING YOURSELF IN SOME WAY	0	1	2	3
SCORING	________ +	_______ +	________ +	________
		= TOTAL SCORE ___________		

IF YOU CHECKED OFF ANY PROBLEMS, HOW DIFFICULT HAVE THESE PROBLEMS MADE IT FOR YOU TO DO YOUR WORK, TAKE CARE OF THINGS AT HOME, OR GET ALONG WITH OTHER PEOPLE?

NOT DIFFICULT AT ALL	SOMEWHAT DIFFICULT	VERY DIFFICULT	EXTREMELY DIFFICULT
☐	☐	☐	☐

MEMORY

IN THE LAST MONTH, HOW OFTEN DO YOU HAVE TROUBLE CONCENTRATING OR FOCUSING ON TASK?
☐ NEVER ☐ SOMETIMES ☐ USUALLY ☐ ALWAYS

IN THE LAST MONTH, HOW OFTEN DID YOU HAVE TROUBLE REMEMBERING OR THINKING CLEARLY?
☐ NEVER ☐ SOMETIMES ☐ USUALLY ☐ ALWAYS

PAIN SCREENING

1. DO YOU HAVE PAIN? ☐ YES ☐ NO
2. IF YES, IS YOUR PAIN DAILY? ☐ YES ☐ NO
3. ON A SCALE OF 0 TO 10 (10 BEING THE WORST PAIN) WHAT IS CURRENT LEVEL OF PAIN? ____/10
4. DOES YOUR PAIN LIMIT YOUR DAILY ACTIVITY? ☐ YES ☐ NO
5. HOW ARE YOU TREATING YOUR PAIN? ☐ OPIOIDS ☐IBUPROFEN/NAPROXEN ☐ TYLENEOL ☐ EXERCISE
   ☐ STRETCHES ☐ COLD/WARM PACKS ☐ MASSAGE ☐ CHIROPRACTOR ☐ TENS UNIT
   ☐ OTHER (PLEASE SPECIFY) ____
6. WHICH PROVIDER(S) ARE MANAGING YOUR PAIN? ☐ PAIN MANAGEMENT ☐ ORTHOPEDICS ☐ PCP
   ☐ OTHER (PLEASE SPECIFY) ____

ANNUAL WELLNESS VISIT QUESTIONAIRE

***NAME*____ *D.O.B.*______/________/__________**

ALLERGIES: LIST ANY NEW ALLERGIES TO MEDS, MEDICAL SUPPLIES, AND/OR FOOD IN THE PAST YEAR

ALLERGY REACTION

1.______________________________________ ____

2.______________________________________ ____

3.______________________________________ ____

MEDICATIONS: LIST ALL CURRENT PRESCRIPTIONS, OVER-THE-COUNTER MEDS, AND SUPPLEMENTS

NAME STRENGTH DIRECTION PRESCRIBED BY

1.____

2. ____

3.____

4.____

5.____

6. ____

7.____

8.____

Do you need help taking your medications? ☐ Yes ☐ No

Reminder- It is your responsibility to notify your doctor of all the prescriptions, over-the-counter medications, and supplements that you are taking during each visit. Nonadherence or noncompliance with treatment plans can often increase the exacerbation of disease or risk of death for patients with certain medical conditions like diabetes, hypertension, and heart disease amongst others.

HOME SAFETY SCREENING

1. WHO LIVES IN THE HOME WITH YOU? ____
2. DO YOU HAVE PETS? ☐ Yes ☐ No
3. DO YOU HAVE EASY ACCESS TO A PHONE AT HOME? ☐ Yes ☐ No
4. DO YOU NEED HELP USING THE PHONE? ☐ Yes ☐ No
5. ARE EMERGENCY NUMBERS EASILY ACCESSIBLE? ☐ Yes ☐ No
6. DO YOU HAVE FUNCTIONING SMOKE/CARBON MONAXIDE ALARMS IN YOUR HOME? ☐ Yes ☐ No
7. DO YOU HAVE NON-SLIP SURFACE AND GRAB BARS IN THE BATH/SHOWER? ☐ Yes ☐ No

ANNUAL WELLNESS VISIT QUESTIONAIRE

***NAME*____ *D.O.B.*______/_________/___________**

TOBACCO SCREENING
ARE YOU A? ☐ NEVER A SMOKER ☐ FORMER SMOKER ☐ CURRENT DAILY SMOKER ☐ CURRENT SOMEDAY SMOKER ☐ CHEWING TOBACCO USER ☐ E- CIG USER ☐ VAPOR USER
IF A *FORMER SMOKER*, HOW LONG HAS IT BEEN SINCE YOU LAST SMOKED? ☐ < 1 MONTH ☐ 1-6 MONTHS ☐ 6-12 MONTHS ☐ 1-5 YEARS ☐ 5-10 YEARS ☐ 10-15 YEARS ☐>15 YEARS
IF A *CURRENT OR FORMER SMOKER*, WHEN WAS YOUR LAST LUNG CANCER SCREENING? (Adults ages **50 to 80 years** who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.) ________/____________/______________ ***Staff Use Only: How many smoking pack years #*__________**
HOW OLD WERE YOU WHEN YOU STARTING SMOKING?
IF *CURRENT DAILY SMOKER*, HOW MANY CIGARETTES DO YOU SMOKE PER DAY? ☐ 5 OR LESS ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 OR MORE
IF *CURRENT DAILY SMOKER*, ARE YOU INTERESTED IN QUITTING? ☐ READY TO QUIT ☐ THINKING ABOUT QUITTING ☐ NOT READY TO QUIT

IMMUNIZATIONS

LAST DOSE REACTIONS NEXT DOSE DUE

COVID____

FLU____

HEPATITIS B ____

HPV____

PNEUMONIA ____

SHINGLES____

TETANUS ____

PREVENTION SCREENINGS- PLEASE LIST THE DATE OF YOUR LAST SCREENING

AAA (ABDOMINAL AORTIC ANEURYSM) SCREENING (SMOKERS, CURRENT AND FORMER- AGES 65-75 OR FAMILY HX AAA) __________________ EKG____

COLONOSCOPY/COLOGAURD (AGE 45-75) ______________________________

LUNG CANCER SCREENING (SMOKING HX IN THE PAST 15 YRS AGES 50-80) ___________________________

DENTAL EXAM____________________________ EYE EXAM ______________________________________

ANNUAL WELLNESS VISIT QUESTIONAIRE

NAME**_______________________________________** ***D.O.B.*****______/________/__________**

PREVENTION SCREENINGS CONTINUED

HGB A1C (ANY PREDIABETIC OR DIABETIC) ____________URINE MICROALBUMIN______________

HEARING EXAM___________________________LABS___________________________________

DEXA/BONE DENSITY (AGE 50-75) ___________________________

MAMMOGRAM (FEMALE AGES 40+) _________________________
PAP SMEAR/ PELVIC EXAM (FEMALES AGES 21-75) __________________________

PROSTATE EXAM _______________________ PSA __________________________________

NUTRITRION

NUMBER OF SERVINGS OF FRUITS DO YOU HAVE A DAY?
☐ 1-3 ☐ 4-7 ☐ 8-10 ☐ >10 ☐ I DO NOT EAT FRUIT

NUMBER OF SERVINGS OF VEGETABLES DO YOU HAVE A DAY?
☐ 1-3 ☐ 4-7 ☐ 8-10 ☐ >10 ☐ I DO NOT EAT VEGETABLES

DO EAT A LOW SODIUM DIET? ☐ YES ☐ NO
DO EAT A LOW-FAT DIET? ☐ YES ☐ NO
DO YOU EAT A LOW CARB DIET? ☐ YES ☐ NO

EXERCISE

HOW MANY DAYS A WEEK DO YOU EXERCISE? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
DURATION: ☐ 30 MIN EACH TIME ☐ < 30 MIN EACH TIME ☐ > 30 MIN EACH TIME

ADVANCE CARE DIRECTIVES

DO YOU WISH TO DISCUSS YOUR END-OF-LIFE MEDICAL TREATMENT DECISIONS AND OR/ WHO YOU DESIGNATE TO MAKE DECISIONS FOR YOU IF YOU ARE UNABLE TO SPEAK FOR YOURSELF? ☐ YES ☐ NO

DO YOU HAVE A LIVING WILL? ☐ YES ☐ NO

DO YOU HAVE A DURABLE MEDICAL (HEALTHCARE) POWER OF ATTORNEY? ☐ YES ☐ NO

IF YES, WHO IS IT? ____

IF YOU HAVE A LIVING WILL OR DMPOA, PLEASE PROVIDE COPIES FOR YOUR CHART AS SOON AS POSSIBLE

STAFF USE ONLY
REVIEWED WITH: ____DATE______/______/_______