Name: _____ **Date of Birth**: _____

Please fill out completely before your scheduled Annual Wellness Visit

Recent History

Have you been admitted to the hospital in the last year? ☐Yes ☐No

Recent Surgeries/Procedures: _____

Physical Activity/Lack of Exercise

How many days a week do you usually exercise? _____

On days when you exercise, for how long do you exercise? _____

How intense is your typical exercise (circle one) Light (like stretching, slow walking)
Moderate (like jogging or swimming)
Very Heavy (Like fast running, stairs)
I am currently not exercising

Smoking/Tobacco use

Do you currently smoke cigarettes? ☐Yes ☐No

Are you a former smoker? ☐Yes ☐No

If you quit smoking, how long ago did you quit? _____

Do you use other tobacco products? ☐Yes ☐No

If you use other tobacco products, what do you use? _____

Alcohol Use

In a typical week, how many days do you drink alcohol? _____

On days when you drink alcohol, how many drinks do you consume? _____

In a typical week, how often do you drink more than 5 alcoholic beverages? _____

Nutrition

On a typical day, how many servings of fruit and/or vegetables do you eat? _____

On a typical day, how many servings of high fiber/ whole grain foods do you eat? _____

On a typical day, how many servings of fried/ high fat foods do you eat? _____

On a typical day, how many servings of Sweets/pasta/white bread do you eat? _____

Motor Vehicle Safety

Do you always fasten your seat belt when you are in the car? ☐Yes ☐No

Do you ever drive after drinking, or ride with a driver who has been drinking? ☐Yes ☐No

Sun Exposure

Do you protect yourself from the sun when you are outdoors? ☐Yes ☐No

Blood Pressure Screen

When was your most recent blood pressure check? _____

What was the level? _____

Cholesterol Screen

If your cholesterol was checked within the last year, what was your total cholesterol? _____

Blood Glucose Screen

If your glucose was checked in the past year, what was your fasting blood sugar level? _____
Have you ever been told by a health professional or doctor that you have diabetes or high blood sugar?_____
Have you had your Hemoglobin A1C checked within the past year? What was it? _____

Daily Aspirin Use

Do you take a daily aspirin? ☐Yes ☐No

Stress Screen

How often is stress a problem for you? _____
How well do you handle stress? _____

Social/Emotional Support

How often do you get the social and emotional support you need? _____

General Life Screen

In general, how satisfied are you with your life? ☐Fair ☐ Poor ☐Good ☐ Excellent
In general, would you say your physical health is? ☐Fair ☐Poor ☐Good ☐Excellent
How would you compare it to last year? ☐Same ☐Better ☐Worse
How would you rate your mental health? ☐Fair ☐Poor ☐Good ☐Excellent
How would you compare it to last year? ☐Same ☐Better ☐Worse

Sleep Assessment

How many hours of sleep do you get each night? _____

Vision Screen

Month and year of last eye exam: _____
Provider: _____
Impairment: ☐Glasses ☐Contacts ☐Cataracts ☐Other (please specify):_____

Hearing

Do you wear hearing aids? ☐Yes ☐No
Do you find it difficult to follow a conversation in a noisy restaurant or crowded room? ☐Yes ☐No
Do you feel that people are mumbling or not speaking clearly? ☐Yes ☐No
Do you experience ringing or noises in your ears? ☐Yes ☐No
Do you hear better with one ear than the other? ☐Yes ☐No
Do you feel handicapped by a hearing problem? ☐Yes ☐No

Mobility

Do you use any mobility aides? Check all that apply
☐ Walker ☐ Cane ☐ Wheelchair ☐ Other (please specify) _____

Fall Risk Assessment

Have you fallen in the last year? ☐Yes ☐No
If yes, how many times have you fallen? _____
Describe what caused you to fall, or what were you doing when you fell?
_____

Have you experienced difficulty with any of the following situations?

☐ Lower extremity weakness ☐ Walking/ unstable balance ☐ Dizziness

Incontinence Assessment

In the past 6 months, have you accidentally leaked urine? ☐Yes ☐No
How much of a problem, if any, was the urine leakage for you? _____
Have you received medications, surgery or given bladder training exercises for urinary incontinence?
_____

Dependency Screen
((YES for independent or NO for dependent))
Are you independent with the following activities?

Bathing	☐Yes ☐No	Telephone use	☐Yes ☐No
Dressing	☐Yes ☐No	Shopping/Errands	☐Yes ☐No
Toileting	☐Yes ☐No	Laundry/Housekeeping	☐Yes ☐No
Feeding	☐Yes ☐No	Preparing meals	☐Yes ☐No
Transportation	☐Yes ☐No		
Taking Medications	☐Yes ☐No		
Managing Finances	☐Yes ☐No		

Because of financial concerns, do you have to make choices between food, medication, heat or necessities?

☐Yes ☐No

What do you have to give up due to financial concerns?
☐Food ☐Medication ☐Electric/gas services ☐Telephone ☐Transportation

COVID STATUS

Have you been diagnosed with COVID-19? ☐Yes ☐No
Have you been vaccinated for COVID-19? ☐ Fully vaccinated ☐Partially vaccinated ☐No
Have you had your COVID-19 Booster? ☐Yes ☐No

Depression Screening

Please **circle** the correct number next to each question below:

Not at all =0 Several days =1 More than half the days=2 Nearly every day=3

Over the past 2 weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling tired or having little energy?	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
Trouble falling asleep, staying asleep or sleeping too much	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself- or that 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 have noticed. Or the opposite, being so fidgety or 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**

Social

Who could help you in case of an emergency? _____

Emergency contact phone number: _____

Marriage Status: ☐Single ☐Married ☐Divorced ☐ Widowed ☐Cohabiting

Lives with: ☐Alone ☐Spouse/Partner ☐Family ☐Institution (if so, where?) _____

Are you sexually active: ☐Yes ☐No

Do you feel safe in your home: ☐Yes ☐No

Employment Status: ☐Working ☐Retired ☐Disabled ☐Unemployed

Advanced Directive

Do you have an Advanced Directive regarding end of life planning? ☐Yes ☐No

If so, **please bring a copy of it with you to your appointment**. If you do not have one, we will review this with you and discuss your wishes you place here:

Is there someone that will make medical decisions for you in the event that you cannot? ☐Yes ☐No

If so, whom? _____ What is your relationship to this person?_____

Do you have a "**Do Not Resuscitate Order**"? ☐Yes ☐No

Are you an organ donor? ☐Yes ☐No

If needed, would you want Hospice/palliative Care? ☐Yes ☐No

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If you knew you would make a quick and full recovery, would you accept any of the following?

CPR	☐Yes ☐No	Ventilator	☐Yes ☐No
Artificial Nutrition	☐Yes ☐No	Artificial Hydration	☐Yes ☐No

- Month and year of last **Tetanus vaccine**: _____
- Month and year of last **Pneumonia vaccine**: _____
- Month and year of last **Shingles**: _____
- Month and year of last **Mammogram**: _____ Provider or facility name: _____
- Month and year of last **Colonoscopy**: _____ Provider or facility name: _____
- Month and year of last **Pap smear**: _____ Provider or facility name: _____
- Month and year of last **Bone Density**: _____ Provider or facility name: _____

List of Specialists:

1._____Speciality:_____

2._____Speciality:_____

3._____Speciality:_____

4._____Speciality:_____

5._____Speciality:_____

6._____Speciality:_____