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: _____

Marriage and Sexuality

- Marriage Status: ☐Single ☐Married ☐Divorced ☐ Widowed ☐Cohabiting
- Are you sexually active? ☐Yes ☐No
- If yes, do you use protection? ☐Yes ☐No

Education and Occupation

- What is the highest grade of level of school you have completed or the highest degree you have received? _____
- Employment Status: ☐Working ☐Retired ☐Disabled ☐Unemployed

Diet and Exercise

- What is your exercise level? ☐Light ☐ Moderate ☐Heavy ☐ Not currently exercising
- How many times per week do you exercise? ☐>1 times ☐ 1-2 times ☐3-4 times ☐ 5-7 times
- On days when you exercise, how many minutes on average do you exercise?

  ☐ 5-10 minutes ☐ 15-30 minutes ☐30-60 minutes ☐ 60+ minutes
- What type of exercise activities do you typically do? _____
- How many servings of fruit and/or vegetables do you typically eat? _____
- How many servings of high fiber/whole grain foods do you typically eat? _____
- How many servings of fried/high fatty foods do you typically eat? _____
- How many servings of high carb content (sweets, pasta, white bread etc.) do you typically eat? _____

Substance Use

- Do you currently smoke cigarettes? ☐Yes ☐No
- Are you a former smoker? ☐Yes ☐No

If **yes**, at what age did you start smoking? ☐Yes ☐No

  - How many years have you smoked? _____

- 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? _____
- If current smoker, do you wish to quit smoking? ☐Yes ☐No
- 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? _____
- If you currently drink alcohol, do you wish to quit? ☐Yes ☐No

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? _____

Home and Environment

- Lives with: ☐Alone ☐Spouse/Partner ☐Family ☐Institution (if so, where?) _____
- Do you feel safe at home? ☐Yes ☐No

Social/Emotional Support

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

Sun Exposure

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

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

COVID Status

- Have you been diagnosed with COVID-19 in the past year? ☐Yes ☐No

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

Dependency Screen

▪ Do you need help with dressing, eating, bathing, going to the bathroom, walking, or getting in or out of bed? ☐Yes ☐No

▪ Do you need help with preparing meals, transportation, shopping, managing your finances, keeping house, making calls, or taking your medicine? ☐Yes ☐No

Hearing Screen

▪ 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

▪ If you answered **yes** to any of the above, would you be interested in a referral for a hearing exam? ☐Yes ☐No

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Mobility

▪ Do you use any mobility aides? Check all that apply

☐ Walker ☐ Cane ☐ Wheelchair ☐ Other (please specify) _____

Vision Impairment: ☐Glasses ☐Contacts ☐Cataracts ☐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 you were doing when you fell? _____

▪ Do you feel unsteady when standing or walking? ☐Yes ☐No

▪ Do you worry about falling? ☐Yes ☐No

Sleep Assessment

▪ How many hours of sleep do you typically get each night?

☐ Less than 4 hours ☐ 4-6 hours ☐ 7-8 hours ☐ 8+ hours

Incontinence Assessment

- In the past 6 months, have you accidentally leaked urine? ☐Yes ☐No
- If **yes**, how much of a problem was this for you? ☐ Not at all ☐ Somewhat ☐ Very ☐ Extremely
- Are you interested in discussing treatment options for urinary incontinence? ☐Yes ☐No

Financial

- Because of financial concerns, do you have to make choices between food, medication, heat or necessities? ☐Yes ☐No

- If you answered **yes,** specifically what do you have to give up due to financial concerns?

☐Food ☐Medication ☐Electric/gas services ☐Telephone ☐Transportation

Advanced Directive

- Do you have an Advanced Directive regarding end of life planning? ☐Yes ☐No
- Do you have a Do Not Resuscitate order? ☐Yes ☐No
(meaning **no** medical intervention used in an emergency situation)
- If needed, would you want hospice/palliative care? ☐Yes ☐No

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If you **have** an Advance Directive, please bring a copy of it with you to your appointment.

- Who could help you in case of an emergency? _____
- What is their relation to you? _____
- Emergency contact phone number: _____

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

- If so, whom? _____ ▪ What is their relation to you? _____

- Do you have a power of attorney? ☐Yes ☐No
(a person granted the authority to make **financial decisions** on your behalf if you are unable)
- Would you accept a blood transfusion in a medical emergency if needed? ☐Yes ☐No
- Are you an organ donor? ☐Yes ☐No

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

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

Depression Screening

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: _____

10. 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 _____

Preventative Care

- 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: _____
- Month and year of last **Eye Exam**: _____ Provider or facility name: _____
  - If you have diabetes, was there any detection of diabetic retinopathy during your eye exam?
    - ☐Yes ☐No
    - If **yes**, please specify which eye was positive for diabetic retinopathy: _____

List of Specialists:

1._____Speciality:_____

2._____Speciality:_____

3._____Speciality:_____

4._____Speciality:_____

5._____Speciality:_____