Date:

Annual Wellness Exam Questionaire

Patient Name:_____ DOB:_____

Do you use Tobacco? **Yes No** Do you use Alcohol? **Yes No**

Have you been depressed lately? **Yes No** Had less interest in doing things? **Yes No**

HEALTH RISK ASSESSMENT

How do you rate your overall Health: (circle one) **EXCELLENT GOOD FAIR POOR**

Do you have any concerns about Managing your health care? Check all that apply

[ ] Unsafe Environment [ ] Transportation [ ] Fall a lot [ ] Difficulty with instructions

[ ] No support at home [ ] Financial difficulty [ ] None of the above

In the last 6 months, how many times have you been to the emergency room? _____

In the last 6 months how many times have you been admitted to the hospital? _____

ACTIVITIES OF DAILY LIVING

Which of the following can you do without assistance? Check all that apply

[ ] Bathing [ ] Dressing [ ] Eating [ ] Walking [ ] Transferring in/out of chairs

[ ] shopping

[ ] Using restroom [ ] Using the phone [ ] Housework [ ] Handle finances

[ ] Transportation

[ ] Make meals [ ] Take medication [ ] None of the above [ ] Completely Independent

Does anyone help you at home? **Yes No** If so who helps you?_____

Have you been experiencing Urinary leakage? **Yes No**

RISK SCREENING

Have you had any issues with Vision? **Yes No** Do you wear glasses? **Y/N** Contacts? **Y/N** Readers? **Y/N** Do you have an eye Doctor? **Yes No**

Have you had any issues with Hearing? **Yes No**

Do you or your family have any concerns about your memory? **Yes No**

PLEASE COMPLETE REVERSE SIDE!!!!!!!!!!!!!!!!!!!

FALL RISK SCREENING

Have you fallen in the last year? **Yes No** How many times? ___ Injured? **Yes No**

Are you afraid of falling? **Yes No**

Do you have trouble with your Balance? **Yes No**

Do you use any assistive devices? Circle all that apply: **None Cane Walker Wheelchair**

Do you currently see any other Providers or Specialists, If so please list facility or doctor?

_____

_____

PREVENTATIVE SCREENING

Have you ever had the following vaccines? Answer if it applies

Flu Date Received_____ Shingles (age 50+) Received **Yes No**

Pneumococcal conj PCV13 (age 65+) Received **Yes No**

Pneumococcal polys PPSV23 (age 65+) Received **Yes No**

Have you ever had a Colonoscopy (age 45-75yrs)? **Yes No**

When?_____ Where? _____When is next due? _____

MALES

Aortic Ultrasound (smokers age 65-75yrs) When? _____
Where?_____

FEMALES

PAP Smear (age 18-65yrs) When?_____ Where?_____

Hysterectomy? **Yes No**

Mammogram (age 40-75yrs) When? _____ Where?_____

DEXA/ Bone Density (age 65+ q 5 years) When? _____ Where? _____