Annual Wellness Visit
Questionnaire

PATIENT INFORMATION

Date: _____ / _____ / _____

Name: _____ _____ _____
LAST FIRST MIDDLE

Date of Birth: _____ / _____ / _____

Home Address: _____ _____ _____ _____ _____
STREET APT/UNIT CITY STATE ZIP CODE

Gender: Female Male

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Social Security Number: _____ - _____ - _____

Next of Kin (for emergency): _____ DOB: _____ / _____ / _____

Next of Kin Phone Number: (_____) _____ - _____

Name of Spouse: _____ Spouse Phone Number: (_____) _____ - _____

1st Insurance: Name _____ Phone Number: (_____) _____ - _____

Policy Number: _____ Group Number: _____

CURRENT MEDICAL

LIST ANY CURRENT MEDICAL PROBLEMS OR CONDITIONS:

1) _____ 7) _____
2) _____ 8) _____
3) _____ 9) _____
4) _____ 10) _____
5) _____ 11) _____
6) _____ 12) _____

PAST MEDICAL

CHILDHOOD ILLNESSES

1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____

CHRONIC ILLNESSES

1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____

Last Eye/Glaucoma Exam: _____

PAST SURGERIES

SURGERY	DATE	SURGERY	DATE
1) _____	_____	2) _____	_____
3) _____	_____	4) _____	_____

Patient Name: _____ Date of Birth: _____ / _____ / _____

PAST MEDICAL

LIST ANY OTHER HOSPITAL STAYS

REASON	DATE	REASON	DATE
1) _____	_____	2) _____	_____
3) _____	_____	4) _____	_____
5) _____	_____	6) _____	_____

PHYSICIANS/PRACTIONERS YOU CURRENTLY SEE

NAME	SPECIALITY	NAME	SPECIALTY
1) _____	_____	2) _____	_____
3) _____	_____	4) _____	_____

ALLERGIES

LIST ANY ALLERGIES TO MEDICATION, X-RAY DYES, OR FOOD

ALLERGY	REACTION
_____	_____
_____	_____
_____	_____

MEDICATIONS

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING, INCLUDING OVER-THE-COUNTER MEDICATIONS

NAME	STRENGTH	DIRECTION	PRESCRIBED BY

SOCIAL HISTORY

Do you drink alcohol? YES NO If yes, how much? _____

Are others concerned about drinking? YES NO

Diet *(circle one)*: BALANCED VEGETARIAN DIABETIC LOW SALT LOW FAT LOW CARB OTHER: _____

Education *(circle one)*: HIGH SCHOOL COLLEGE SOME COLLEGE TRADE SCHOOL OTHER: _____

Do you do some form of regular exercise every day? YES NO If yes, how much? _____

Marital Status: MARRIED SINGLE DIVORCED WIDOWED OTHER: _____

Are you employed? YES NO Occupation: _____

List everyone in your household *(including pets)*:

_____ _____ _____ _____

_____ _____ _____ _____

Do you wear seatbelts? YES NO

Have you ever smoked? YES NO If yes, how many packs per day? _____

Do you chew tobacco? YES NO If yes, how much? _____

Patient Name: _____ Date of Birth: _____ / _____ / _____

SOCIAL HISTORY CONTINUED

ROUTINE TASKS: ***Please indicate if you do or do not need help performing these routine tasks***

1) Feeding yourself	❑ No	❑ Yes	If yes, who helps? _____
2) Getting from bed to chair	❑ No	❑ Yes	If yes, who helps? _____
3) Getting to the toilet	❑ No	❑ Yes	If yes, who helps? _____
4) Getting dressed	❑ No	❑ Yes	If yes, who helps? _____
5) Bathing or showering	❑ No	❑ Yes	If yes, who helps? _____
6) Walking across the room **(Includes using cane or walker)**	❑ No	❑ Yes	If yes, who helps? _____
7) Using the telephone	❑ No	❑ Yes	If yes, who helps? _____
8) Taking your medications	❑ No	❑ Yes	If yes, who helps? _____
9) Preparing meals	❑ No	❑ Yes	If yes, who helps? _____
10) Managing money **(like keeping track of expenses or paying bills)**	❑ No	❑ Yes	If yes, who helps? _____
11) Moderately strenuous housework such as doing laundry	❑ No	❑ Yes	If yes, who helps? _____
12) Shopping for personal items like toiletries or medications	❑ No	❑ Yes	If yes, who helps? _____
13) Shopping for groceries	❑ No	❑ Yes	If yes, who helps? _____
14) Driving	❑ No	❑ Yes	If yes, who helps? _____
15) Climbing a flight of stairs	❑ No	❑ Yes	If yes, who helps? _____

FAMILY HISTORY

	FATHER	MOTHER	SISTERS	BROTHERS	GRANDMOTHER	GRANDFATHER	DAUGHTER	SON
DECEASED								
HIGH BLOOD PRESSURE								
HEART PROBLEMS								
STROKE								
OBESITY								
GENETIC DISORER								
ALCOHOLISM								
LIVER DISEASE								
DEPRESSION								
CANCER SPECIFY:_____								
OTHER:								

Patient Name: _____ Date of Birth: _____ / _____ / _____

HEALTH MAINTENANCE

PLEASE RECORD THE LAST YEAR YOU HAD THE FOLLOWING. IF YOU DO NOT KNOW, LEAVE BLANK. IF NEVER, WRITE NEVER

Hep B (shot)	_____	Hearing Exam	_____
Flu Vaccine (shot)	_____	Hemocult	_____
Pneumonia Vaccine (shot)	_____	Lipid Panel	_____
Tetanus Diphtherias Vaccine (shot)	_____	Mammogram	_____
Zostavax (shot)	_____	Nutritional Therapy	_____
Abdominal Aortic Aneurysm Screening	_____	PAP Smear	_____
Bone Density Scan	_____	Pelvic Exam	_____
Colonoscopy	_____	Prostate Exam	_____
Diabetes Self Management Training	_____	PSA Test	_____
Echocardiogram	_____	Rectal Exam	_____
Eye Glaucoma Exam	_____	Smoking Cessation	_____
Glucose	_____		

HEARING

HEARING: CHECK YES, NO, OR SOMETIMES FOR *EACH* QUESTION

1) Do you find it difficult to floor a conversation in a noisy restaurant or a crowded room?	❑ No	❑ Yes	❑ Sometimes
2) Do you sometimes feel that people are mumbling or not speaking clearly?	❑ No	❑ Yes	❑ Sometimes
3) Do you have trouble following dialogue in the theater?	❑ No	❑ Yes	❑ Sometimes
4) Do you sometimes find it difficult to understand a speaker at a public meeting or religious service?	❑ No	❑ Yes	❑ Sometimes
5) Do you find yourself asking people to speak up or repeat themselves?	❑ No	❑ Yes	❑ Sometimes
6) Do you find men's voices easier to understand than women's?	❑ No	❑ Yes	❑ Sometimes
7) Do you have trouble understanding speech on the telephone?	❑ No	❑ Yes	❑ Sometimes
8) Do you sometimes have difficulty understanding speech on the Telephone?	❑ No	❑ Yes	❑ Sometimes
9) Does a hearing problem cause you to feel embarrassed when meeting new people?	❑ No	❑ Yes	❑ Sometimes
10) Do you feel handicapped by a hearing problem?	❑ No	❑ Yes	❑ Sometimes
11) Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?	❑ No	❑ Yes	❑ Sometimes
12) Do you experience ringing or noises in your ears?	❑ No	❑ Yes	❑ Sometimes
13) Do you hear better with one ear than the other?	❑ No	❑ Yes	❑ Sometimes
14) Have you had any significant noise exposure during work, recreation, or military service?	❑ No	❑ Yes	❑ Sometimes
15) Have any of the relatives (by birth) had hearing loss?	❑ No	❑ Yes	❑ Sometimes

Patient Name: _____ Date of Birth: _____ / _____ / _____

FALL RISK SCREENING

PLEASE CHECK THE APPROPRIATE ANSWER

1) Are you afraid of falling? ❑ No ❑ Yes
2) Have you fallen in the past year? ❑ No ❑ Yes

If yes, circle the circumstances surrounding the fall

Answers:

- *Tripped over something*
- *Lightheadedness or palpitations prior to falling*
- *Loss of consciousness*
- *Injured*
- *Needed to see a doctor*
- *Able to get up on own*

ADVANCE DIRECTIVE

Do you have an Advanced Directive (living will)? ❑ No ❑ Yes

Notes: _____

_____

_____

_____

_____

Authorized Signature: _____ Date: _____

Reviewed By: _____ Date: _____