

ANNUAL WELLNESS ASSESSMENT

Thank you for taking the time to complete this survey.

Name: _____ Appointment Date: _____

Date of Birth: ____/____/____ Preferred Language: _____

Race/Ethnicity: American Indian Asian Hispanic African American Caucasian
 Native Hawaiian Pacific Islander Other _____

In general, how would you rate your health?

Excellent Very Good Good Fair Poor

How often is anxiety or stress a problem for you in handling:

Please circle one	Not at all	Several days	More than half the days	Nearly Every day
a. Your health	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. Your Finances	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. Your family or social relationship	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
d. Your work	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

In the past week, did you need help from others to perform every day activities such as: eating, getting dressed, grooming, bathing, walking, or using the bathroom?

No Yes If "Yes", please describe: _____

In the past week, did you need help from other to take care of things such as laundry, housekeeping, shopping, using the telephone, food preparation, transportation, or taking your medication?

No Yes If "Yes", please describe: _____

Please list all providers and suppliers of your medical care such as primary care physicians, specialty physicians, chiropractors, pharmacies, herbalists and therapists.

Primary Care Physician(s)	Specialty
Other Patient Care Team members	Specialty

Family History: Please check the appropriate box of the conditions that apply to your blood relatives:

Relation	Alive	Deceased	Alcohol abuse	Arthritis	Asthma	Birth Defects	Cancer	Chronic Obstructive lung disease (COPD)	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Learning Disability	Mental illness	Mental Retardation	Miscarriages	Stroke	Vision loss
	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daughter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family history comments:

Surgical History:

urgery	Yes	No	Place	Date
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brain surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Breast Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Gall Bladder Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Colon surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cosmetic surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
C-Section	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Small intestine surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Fracture surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Spine surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hernia repair	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tubal Ligation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Prostate surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart Bypass	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Vasectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Other surgical history: _____

Over the past 2 weeks how often have you been bothered by:

Please circle one	Not at all	Several days	More than half the days	Nearly Every day
a. Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
b. Feeling down, depressed or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
c. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
e. Feeling Tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
f. Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
g. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
h. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
i. Moving or speaking so slowly that other people could have noticed? Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
j. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Are you being treated for depression with medication ? No Yes

How often do you get the social and emotional support you need?
 Always Usually Sometimes Never

Do you experience any of the following on a regular basis?

a. Getting lost when going for a walk or driving	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Forgetting appointments, family occasions, or holidays	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Becoming more forgetful or can't remember things that happened recently	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d. Having trouble finding the words you want to say or naming people and things	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Have you had any falls in the past year? No Yes If "Yes", How many: _____

- a. If "Yes" , what caused your fall? _____
- b. Do you live alone? No Yes
- c. Do you have stairs in your home? No Yes
- d. Do you have carpet flooring? No Yes
- e. Do you have area rugs? No Yes

Have you had any problems with balance or walking in the past 12 months? No Yes

Do people complain that you turn the TV volume up too high? No Yes

Do you find yourself asking people to repeat themselves? No Yes

Do you have trouble hearing in a noisy background? No Yes

Do you have smoke detectors in your home? No Yes

Do you have carbon monoxide detectors? No Yes

Do family members report that you have difficulty remembering things? No Yes

Please record the last year you had the following. If you do not know, leave blank.

Hepatitis B Vaccine	_____	Tetanus Diphtheria vaccine	_____
Pneumonia vaccine (Pneumococcal 23)	_____	Zostavax (shingles)	_____
Pneumonia vaccine (Pneumococcal 13)	_____	Flu vaccine	_____
Abdom. Aortic Aneurysm Screening	_____	Bone Density Scan	_____
Colonoscopy	_____	Diabetes Self-Management	_____
Echocardiogram	_____	Eye Glaucoma Exam	_____
Glucose	_____	Hearing Exam	_____
FOBT (Fecal Occult Blood Test)	_____	Lipid Panel	_____
Mammogram	_____	Nutritional Therapy	_____
Pap Smear	_____	Pelvic Exam	_____
Prostate Exam	_____	PSA Test	_____
Rectal Exam	_____	Smoking Cessation	_____

How would you describe the condition of your mouth & teeth, including false teeth or dentures?

Excellent Very Good Good Fair Poor

During the past 4 weeks, how much bodily pain did you generally have?

No Pain Very Mild Pain Mild Pain Moderate Pain Severe Pain

Many people experience problems urinary incontinence (the leakage of urine):

a. the past 6 months, have you accidentally leaked urine? No Yes
b. If "Yes" would you like to discuss treatment option? No Yes

Have you ever smoked cigarettes, a pipe, cigars, or chewed tobacco?

No Yes
a. If "Yes", are you currently smoking or using tobacco? No Yes
b. If "Yes". would you like assistance to stop using tobacco? No Yes

During the past month, how many drinks of wine, beer, or other alcoholic beverages did you have?

None 1 drink per week 2-6 drinks per week 6-9 drinks per week 10 or more per week

Do you exercise or do moderate physical activity such as walking 5 days a week? No Yes

How many of the following do you typically eat each day?

a. Fruits and vegetable _____ serving / day
b. High fiber or whole grain foods _____ serving / day
c. Fried or high- fat food _____ serving / day
d. Sugar-sweetened (not diet) beverages _____ serving / day

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

Do you have Advanced Directive, Living Will or a POLST? No Yes

General

Do you eat a well-balanced diet? Yes No
Approx. weight now _____ 1 yr ago _____
Maximum weight _____
Exercise? Frequency/Wk _____
Activities _____
Any sexual concerns? Yes No

Year of Last Complete Physical _____

Headaches Yes No
Glasses/Contacts Yes No
Double Vision Yes No
Eye disease or injury Yes No

Year Last Checked for Glaucoma _____

Itching eyes or nose/Hay Fever Yes No
Septal deviation/polyps Yes No
Nosebleeds Yes No
Sinus trouble Yes No
Ear disease Yes No
Impaired hearing Yes No
Ringing in the ears Yes No
Hoarseness Yes No

NECK

Stiffness Yes No
Enlarged glands Yes No
Injury Yes No

RESPIRATORY

Coughing up blood Yes No
Chronic cough (including Smoker's Cough) Yes No
Wheezing Yes No
Shortness of breath Yes No
How many blocks can you walk without having to catch your breath? _____
Night sweats Yes No
Skin test for Tuberculosis Yes No
If yes, year tested & results _____
Year of last chest x-ray _____

CARDIOVASCULAR

Chest pain or Angina pectoris Yes No
Shortness of breath when lying flat Yes No
Pain in legs when walking, relieved at rest Yes No
Varicose Veins Yes No
Ankles often badly swollen Yes No
Heart murmur Yes No
Rapid, hard or skipped heart beats Yes No
Year of last EKG _____
Have you had a stress treadmill? Year: _____ Yes No

GASTROINTESTINAL

Change in appetite Yes No
Heartburn or indigestion Yes No
Sour taste in throat or mouth Yes No
Intolerance to spicy foods, coffee or alcohol Yes No
Ever vomited blood? Yes No
Do foods stick in throat? Yes No
Gallbladder trouble/intolerance to greasy foods Yes No
Intolerance to milk products Yes No
Hiatal hernia Yes No
Pancreatis Yes No
Do you often vomit? Yes No
Crampy abdominal pain Yes No
Chronic constipation Yes No
Frequent diarrhea Yes No
Change in bowel habits Yes No
Bloody or black bowel movements Yes No
Hemorrhoids or piles Yes No

Did someone other than the patient help fill this out? Yes No

Completed by: _____

Relationship: _____

GENITORURINARY

Loss of urine when cough or sneeze Yes No
Kidney or bladder infection Yes No
Burning or frequent urination Yes No
Feeling must go immediately? Yes No
Do you have to get up at night to urinate? # ____ Yes No
Blood in urine Yes No
Kidney stones Yes No
Swelling of hands and feet Yes No
Difficulty starting urination? Yes No
Decrease I strength of stream Yes No

MUSCULOSKELETAL

Significant arthritis/joint pain Yes No
Low back pain Yes No
Muscle weakness or tenderness Yes No
Difficulty walking Yes No
Fractures: _____

SKIN

Skin disorders: _____ Yes No

NEUROLOGIC / PSYCHIATRIC

Numbness/paralysis Yes No
Fainting spells Yes No
Memory loss Yes No
Dizziness Yes No
Do you have trouble sleeping? Yes No
Are you often depressed? Yes No
Are you often anxious or nervous? Yes No
Do you ever wish you were dead and away from it all? Yes No
Do you often worry? Yes No
Have you ever been under psychiatric care? Yes No

HEMATOLOGIC

Excessive bleeding or abnormal bruising Yes No

ENDOCRINE

Crave large amount of fluids Yes No
Intolerance to slightly warm rooms Yes No
Intolerance to slightly cool rooms Yes No
Change in textures of hair or skin Yes No
Change in voice (as an adult) Yes No
Hair loss Yes No
Diminished sex drive Yes No
Darkening of skin Yes No

GYNECOLOGICAL(This section for women only)

Age when periods started _____ years old
Frequency: every _____ days; Last period: _____
Are they abnormal or irregular? Yes No
Menopausal : Age _____
Number of pregnancies: _____ C/sections: _____
Term deliveries: _____ Premature: _____
Miscarriages: _____ Abortions: _____
Pelvic inflammatory disease Yes No
Pain with intercourse Yes No
Date of last cancer smear _____ **Normal?** Yes No
Breast masses, lumps, cyst Yes No
Nipple discharge Yes No
Skin discoloration/dimpling Yes No
Family history of breast cancer Yes No
Date of last mammogram _____