

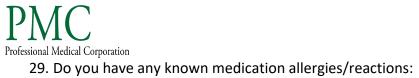
Date:	
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Annual Wellness Questionnaire

Patient	nt Name:	Date of Birth:		Age:	
1	How would you rate your overall heal	th?			
Δ.	Excellent Very Good		Poor	Very Poor	
2.	Do you have any concerns about your		YES	NO	
	If yes, please list your concerns:				
3.					
		Good Fair		Very Poor	
4.	Are you physically active?			YES	NO
	If yes: Type of activity?				
	How many times per week?				
	How many minutes at one time				
5.	Do you characterize yourself as frail?		YES	NO	
	If Yes - Slightly frail Moderately	frail Very frail	Extre	mely frail	
6.	Are you currently using any durable m	edical equipment?		YES	NO
	Please circle: Walker, Wheelchair, Cane, Cr	utches, Hearing Aids, G	lucometer, CI	PAP, Oxygen	
	Other:				
	What is your pain level? 1 2		6 7	8 9	10
8.	•	st year?	YES	NO	
	Date:			\/E0	
9.	Do you have any concerns regarding y	_		YES	NO
4.0	Please list concerns if yes:				
10.). How would you rate your oral health?		., .		
11	,		Very Po		
11.	Have you been to the dentist in the la Date:	st year?	YES	NO	
12.	. How would you rate your diet? Please	e choose one:			
	As Advised By Doctor Very Healthy	Healthy Mo	derately H	ealthy	
	Moderately Poor Poor	Very Poor			
13.	. Do you feel overly tired or fatigued?			YES	NO
14.	. Do you feel lonely or isolated?			YES	NO
15.	. Please list the people currently residin	ng with you and thei	r relationsh	nip to you:	
16.	. How is your stress level?				
	High Moderately high M	loderately low	Low V	ery low	
17.	. Do you have trouble controlling your a	anger?		YES	NO
18.	. Do you currently have a durable powe	er of attorney?		YES	NO
	a. Is it on file with the practice?			YES	NO



ressional ivicultal Co	TPOTATION .					
19. Are yo	ou sexually active?	YES	NO			
a.	Sexual partners –	Men	Women	Both		
b.	Multiple partners?	YES	NO			
20. Do you	u have a history of Sexually Tra	ansmitt	ed Infectior	rs (STI)?	YES	NO
21. Do you	u use or have a history of using	g IV dru	gs?		YES	NO
22. Do you	u wear a seat belt when you d	rive or ı	ride in the c	are?	YES	NO
23. Please	answer the following questio	ns rega	rding your h	nome safety:		
1.	I have steps to enter my hom	ne or sta	airs inside n	ny home	YES	NO
2.	There are handrails on the st	airs			YES	NO
3.	I have loose throw rugs in my	y house			YES	NO
4.	I have clutter on the floors				YES	NO
5.	I have poor household lightir	ng			YES	NO
6.	I have grab bars in the bathro	oom			YES	NO
7.	Do you use any medical equi	pment	while walkii	ng	YES	NO
8.	Have you fallen in the past ye	ear?			YES	NO
24. Please	answer the following questio	ns rega	rding your a	abilities:		
1.	Can you prepare meals without	out assi	stance		YES	NO
2.	Can you dress yourself withou	ut assis	stance		YES	NO
3.	Can you use the toilet withou	ut assist	tance		YES	NO
4.	Can you perform basic hygie	ne with	out assistar	nce	YES	NO
5.	Can you bathe and/or showe	er yours	elf without	assistance	YES	NO
6.	Do you ever lose your balance	e or fal	l when walk	king?	YES	NO
7.	Can you use the phone with	out assi	stance		YES	NO
8.	Can you manage your medica	ation w	ithout assis	tance	YES	NO
9.	Can you access your mode of	f transp	ortation wi	thout assistance	YES	NO
10	. Can you do your own housev	work			YES	NO
11	. Can you manage your finance	es with	out assistan	ice	YES	NO
	. Can you shop without assista				YES	NO
	. Can you do laundry without a				YES	NO
-	ou had any hospital stays in tl	•			YES	NO
If yes,	please provide: Date of servic					
	Name of hosp					
	Reason for ho	•				
•	u have any of the following su	•	•			
•	placement Back/Spinal Surg	•	• •	•	ment	
	Surgery Heart Bypass (CAB	•		Prostate Surgery		
=	u have a family history of an al			•	YES	NO
•	u have a family history of (plea		•		_	
Cance	,					
Stroke	Bipolar Disorder Schizoph	renia l	Heart Diseas	se High Choleste	rol Dia	betes



				
	using any prescribed opioids (pai yl, Hydrocodone, Morphine, Code	·	YES	NO
31. Have you ever into was not prescribe	entionally taken more medicatior d for you?	n than prescribed or	medicat YES	ion that NO
	MEDICATIONS AND SUPPLEMI	ENTS		
	minerals (like calcium), and sup e a written list of your medicatio	-	ver-the-	counter)
dication Name	Dosage and Directions	Reason for Med	lication	
	er doctors and their phone numb ors, dentist, podiatrist, medical e	-	_	e:
Name/Phone:	<u>Name</u>	<u>/Phone</u> :		
				
				
	OFFICIAL LICE CALLY			
iewed By	OFFICIAL USE ONLY			
ician Name:				
nician Signature:		Date:		

YES

NO