NAME: APPT TIME:

MAHEC FAMILY HEALTH CENTER

ANNUAL WELLNESS VISIT Pre-Visit Questionnaire

Before your Annual Wellness Visit, please do your best to answer the following questions.

Thank you!

Outside of MAHEC, list all physicians/ providers you currently see on a regular basis.

Dentist: _____

Eyes: _____

Heart: _____

Endocrine (Diabetes): _____

Kidney: _____

Arthritis: _____

Cancer/Blood: _____

Stomach/Liver: _____

Foot: _____

OB/GYN: _____

Skin: _____

Other: _____

How would you describe your general health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

PHYSICAL ACTIVITY

In general, how many days do you exercise each week? _____ *days*

On days when you exercise, how long do you exercise? _____ *minutes*

How often do you do exercises to strengthen your arms and legs? _____ *days*

When you do exercise, how intense is your typical exercise?

- ☐ Light (like stretching or slow walking)
- ☐ Moderate (like brisk walking)
- ☐ Heavy (like jogging or swimming)
- ☐ Very heavy (like fast running or stair climbing)

What type(s) of exercise do you typically do?

_____

_____

_____

CAFFEINE USE

Do you drink caffeine daily?

☐ Yes ☐ No

If yes, how many servings per day?

_____ cups of coffee

_____ sodas

_____ tea

_____ other:

TOBACCO USE

Please indicate your tobacco history:

☐ Current Tobacco User
_____Packs per day
_____Cans per day

☐ Former Tobacco User
Quit _____*date*
Previously used _____ packs per day
Previously used _____ cans per day

☐ Never used Tobacco

If you are currently using tobacco, would you be interested in quitting in the next month?

☐ Yes ☐ No

ALCOHOL USE

In a given week, how many days do you drink alcohol?_____ *days*

Do you ever drink more than 4 drinks at one sitting?

☐ Yes ☐ No

FALLS

Have you fallen 2 or more times in the past 12 months?

☐ Yes ☐ No

Have you injured yourself in a fall in the past 12 months?

☐ Yes ☐ No

If yes, what was the injury?

_____

_____

_____

_____

_____

_____

HEARING

Do you have any concerns about your hearing?

☐ Yes ☐ No

Would you be interested in a referral to a hearing specialist?

☐ Yes ☐ No

MEMORY

Do you or your family members have any concerns about your memory?

☐ Yes ☐ No

If yes, what are your specific concerns?

_____

_____

_____

_____

ACTIVITIES OF DAILY LIVING

In the past 7 days have you needed help with any of the following activities?

Preparing meals:	☐ Yes	☐ No
Making it to the restroom:	☐ Yes	☐ No
Taking medications:	☐ Yes	☐ No
Dressing:	☐ Yes	☐ No
Laundry/housework:	☐ Yes	☐ No
Bathing:	☐ Yes	☐ No
Shopping for food:	☐ Yes	☐ No
Getting in/out of chairs:	☐ Yes	☐ No
Managing money:	☐ Yes	☐ No
Eating:	☐ Yes	☐ No
Driving:	☐ Yes	☐ No
Using the toilet :	☐ Yes	☐ No
Using the telephone:	☐ Yes	☐ No

In the past 6 months, have you accidentally leaked urine?

☐ Yes ☐ No

FAMILY HISTORY

Have any of your immediate family members (parents, siblings, or children, living or deceased) had the following diseases?

Heart attack: ☐ Yes ☐ No

If yes, who: _____

Stroke: ☐ Yes ☐ No

If yes, who: _____

Diabetes: ☐ Yes ☐ No

If yes, who: _____

Cancer: ☐ Yes ☐ No

If yes, who and what type of cancer:

_____

_____

_____

_____

SURGICAL HISTORY

Please list the TYPE and DATE of any surgeries you have had.

_____

_____

_____

_____

_____

_____

_____

HOME SAFETY

Do you always fasten your seatbelt when driving?

☐ Yes ☐ No

Do you have grab bars on your tub/shower?

☐ Yes ☐ No

Does your home have a working smoke detector?

☐ Yes ☐ No

Do you have firearms in your home?

☐ Yes ☐ No

If you have firearms, are they in a locked, safe location?

☐ Yes ☐ No

Do you have throw rugs scattered throughout your home?

☐ Yes ☐ No

ADVANCE DIRECTIVES

Do you have a living will?

☐ Yes ☐ No

If you haven't already provided MAHEC with a copy of it, please bring us a copy at your convenience.

Do you have a Durable (healthcare) Power of Attorney?

☐ Yes ☐ No

If yes, who is it?

_____

Only one more page to go. ⟶

DEPRESSION SCREENING

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble falling or staying asleep, or sleeping too much

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling tired or having little energy

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Poor appetite or overeating

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling bad about yourself – or that you are a failure or have let yourself or your family down

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble concentrating on things, such as reading or watching television

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Moving or speaking so slowly that other people may have noticed or being fidgety or restless, moving around more than usual

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Thoughts that you would be better off dead, or of hurting yourself in some way

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

HAVE YOU HAD THE FOLLOWING? When? Where?

Colorectal Cancer Screening _____
(such as a colonoscopy)

Osteoporosis Screening _____
(DXA or bone scan)

Mammogram (Women ONLY) _____

Abdominal Aortic Aneurysm Screening _____
(abdominal ultrasound, Men ONLY)

Tetanus Vaccine (Adacel, Boostrix, etc.) _____

Flu Vaccine _____

Pneumonia Vaccine (Pneumovax or Prevnar) _____

Shingles Vaccine (Zostavax) _____