WEST MARION FAMILY PRACTICE

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ANNUAL WELLNESS VISIT QUESTIONNAIRE

PATIENT'S NAME: _____ TODAY'S DATE: _____ DATE OF BIRTH: _____

GENDER: MALE or FEMALE

Please list all of your doctors:

Doctor's Name	Specialty

Please list all of your medications, including all over the counter medications and herbal supplements:

Medication Name	Dose	Frequency

Are you current with all of your preventative health screenings and vaccinations?

Vaccination/Exam			Date Last Completed?	Where Completed?
Pneumonia Vaccination	Yes	No		
Flu Vaccination	Yes	No		
Shingles Vaccination	Yes	No		
Carotid Ultrasound	Yes	No		
Colonoscopy	Yes	No		
Cholesterol screening (HDL,LDL)	Yes	No		
Depression screening	Yes	No		
Mammogram	Yes	No		
(Women Only) PAP/Pelvic Exam	Yes	No		
(Men Only) PSA test	Yes	No		
Vision Exam	Yes	No		
Osteoporosis Screening	Yes	No		

Do you have a: Living Will Health Care Surrogate/Proxy Durable Power of Attorney

Has your mood changed? _____ Yes No

If yes, how? _____

Are you worried about your memory? _____ Yes No

Do you worry about falling? _____ Yes No

PATIENT'S NAME: _____ DATE OF BIRTH: _____

Over ***the last two (2) weeks,*** how often have you been bothered by any of the following problems? (Please use 'X' for each appropriate answer)	**NOT AT ALL**	**SEVERAL DAYS**	**MORE THAN HALF THE DAYS**	**NEARLY EVERY DAY**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed or hopeless				
3. Trouble falling or staying asleep or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself or feeling that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading or watching television				
8. 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				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

If you checked off *any* problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	
	Somewhat difficult	
	Very difficult	
	Extremely difficult	

This was adapted from PHQ-9 from PRIME MD TODAY, developed by Drs Robert L Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc.

PATIENT'S NAME: _____ DATE OF BIRTH: _____

ACTIVITIES OF DAILY LIVING QUESTIONNAIRE

Please mark your comfort level for each activity with an 'X':

Activity	I am Independent	I Need Help	I am Dependent	I Do Not Do
Bathing				
Dressing				
Grooming				
Oral Care				
Toileting				
Transferring				
Walking				
Climbing Stairs				
Eating				
Shopping				
Cooking				
Managing Medications				
Using the phone				
Housework				
Doing Laundry				
Driving				
Managing Finances				

FALL RISK ASSESSMENT

Please circle your answer:

1. Have you fallen before or been injured because of a fall?	YES	NO
2. Do you feel weaker than you used to or have less strength in your arms and legs?	YES	NO
3. Have you stopped doing daily activities or avoided exercise because you are afraid of falling?	YES	NO
4. Do you feel unsteady on your feet or shuffle when you walk?	YES	NO
5. Has your hand strength decreased?	YES	NO
6. Has your eyesight diminished or do you have trouble seeing depth or seeing at night?	YES	NO
7. Do you feel dizzy when you stand up?	YES	NO
8. Have you experienced hearing loss?	YES	NO
9. Do you have foot ulcers, bunions, hammertoes or callouses that hurt or cause you to adjust your steps?	YES	NO
10. Do you experience incontinence?	YES	NO

Patient's Signature: _____ Today's Date: _____