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ANNUAL WELLNESS VISIT QUESTIONNAIRE

PATIENT'S NAME:_____ TODAYS DATE:_____

GENDER: ☐ MALE ☐ FEMALE DATE OF BIRTH:_____

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 preventive health screening and vaccinations?

Vaccination/Exam			Date Last completed?	Where Completed?
Pneumonia vaccine	Yes	No		
Flu vaccine	Yes	No		
Shingles vaccine	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	Yes	No		

Do you have a: ☐ Living Will ☐Health Care Surogate/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

Over **the last 2 weeks** how often have you experienced any of the following problems? **(Please use an (X) for each appropriate answer)**	**Not At All**	**Several Days**	**More Than Half The Days**	**Nearly Every Day**
Little Interest or pleasure in doing things.				
Feeling down, depressed or hopeless.				
Trouble falling or staying asleep or sleeping too much.				
Feeling tired or having little energy.				
Poor appetite or over eating				
Feeling bad about yourself or feeling that you are a failure or have let yourself or your family down.				
Trouble concentrating on things, such as reading or watching television.				
Moving or speaking slowly that other people could have noticed or the opposite being so fidgety or restless that that you have been moving around a lot more than usual.				
Thoughts that you would be better off dead or of hurting yourself in some way.				

<u>If you checked off any problems above</u>, 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	

Patient Signature:_____ Date:_____

LARA MEDICAL AND ASSOCIATES

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 ASSESMENT

Please circle your answer:

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

Patient Signature:_____ Date:_____