***ANNUAL WELLNESS PREVISIT QUESTIONNAIRE***

**This is a multiple page questionnaire- please fill out ALL PAGES before your visit!**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today's Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Today's Visit**

What three questions would you like answered today?   
1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there anything you would like to do to improve your health (please circle):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Eat Healthy Diet/Lose Weight** | **Limit Alcohol** | **Be Physically Active** | **Monitor My Blood Sugar and Blood Pressure** |
| **Stop Smoking** | **Cope with Stress** | **Take My Medicine as Prescribed** | **Other** |

How should we contact you? (circle one)No Preference Letter Telephone Web Portal

What are your preferred languages? (circle as many as you speak)

English American Sign Language French German Spanish

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you having pain today?** Yes No If so, where\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Please rate your pain, if you have any by marking the scale: |

**End of Life Care**:

Do you want to discuss end of life issues? \_\_\_ Yes \_\_\_ No

Do you have an Advanced Directive/Living Will ? \_\_\_ Yes \_\_\_ No

Do we have a copy on file? \_\_\_Yes \_\_\_ No

**ACTIVITIES OF DAILY LIVING : Because of a health or memory problem:**

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | **Do you have any difficulty with…** |
|  |  | bathing or showering? |
|  |  | dressing yourself? |
|  |  | eating or feeding yourself? |
|  |  | toileting and cleaning yourself |
|  |  | getting off/on the toilet, transferring from bed to chair |
|  |  | leaking stool or urine, having to wear pads? |
|  |  |  |
|  |  | driving or transportation |
|  |  | meal/food preparation |
|  |  | shopping or errands |
|  |  | managing your money – such as paying your bills and keeping track of expenses? |
|  |  | using telephone |
|  |  | laundry |
|  |  | walking several blocks? |

**Falls:**

|  |  |  |
| --- | --- | --- |
| Have you fallen in the last year? (check **one** box only) |  | NO |
|  | Once, without injury |
|  | Once WITH INJURY |
|  | 2 Falls or more |
| Do you FEEL UNSTEADY when standing or walking | Yes | No |
| Do you WORRY about falling? | Yes | No |

**Barriers to Care:**

Please check off any barriers you have to care

|  |  |  |  |
| --- | --- | --- | --- |
|  | None |  | I don’t understand English well / Language barrier |
|  | Severe illness |  |  |
|  | Trouble understanding complicated items. Cognitive deficits (trouble thinking) |  | I don’t read well / Literacy (trouble understanding written words) |
|  | My beliefs/culture are so different from my providers it is hard to trust them./ Cultural barrier |  | I forget a lot of things / Memory problems |
|  | Desire/motivation to get better and care for myself |  | My pain makes it hard to come for visits and care / Pain |
|  | I have Difficulty Concentrating (attention problems) |  | I have physical handicaps that make coming to the office difficult/ Physical limitations (handicaps or disabilities) |
|  | Emotional state |  | I have problems finding transportation/ Transportation limitation (caregiver) |
|  | Financial concerns |  | Vision impairment (can’t see well) |
|  | I don’t really understand how my body works or why I’m having health problems / Health literacy (understanding how your body works) |  | Other |
|  | I have trouble hearing / Hearing deficit (trouble hearing) |  |  |

**Preferred Learning Style:** Please check off the way(s) you want to learn things:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | No Preference | Hands On/Showing (Demonstration) | Print Materials | Verbal/Talking | Video/TV |
| You |  |  |  |  |  |
| Your caregivers |  |  |  |  |  |

**Caregivers:** Does anyone help care for you at home?

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Their contact number and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Between Visits**

List all the doctors/ specialists and therapists you see (e.g. eye doctor, bone doctor, dentist, physical therapist, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been to the ER, hospital or another doctor since last seen here? \_\_\_ Yes \_\_\_No   
Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No HEARING AND VISION**:

\_\_ \_\_ Do you have any hearing problems? (Mark yes if family members say you have trouble hearing)

\_\_ \_\_ Do you have any problems with your vision?

Who is your eye doctor?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last eye exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Yes No THINKING AND MEMORY:**

\_\_ \_\_ Does your family say you have memory problems?

\_\_ \_\_ Do you notice problems with your memory?

**Home Safety**

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** |  |
|  |  | Are **emergency numbers** kept by the phone and regularly updated? |
|  |  | Are all household members **aware of the dangers of smoking**, especially in bed? |
|  |  | Are **working smoke alarms and fire extinguishers** available for use? |
|  |  | Are **firearms stored unloaded** and securely locked? |
|  |  | Have **throw rugs been removed** or fastened down? |
|  |  | Are **nonslip mats** in all bath tubs and shower areas? |
|  |  | Are sidewalks and all outdoor **steps clear of tools, toys and other articles**? |
|  |  | Are doorways, halls, and stairs **free of clutter**? |
|  |  | Are all **electrical cords in working order**, easily seen, and not run under rugs/carpets or wrapped around nails? |

**Depression Screen:**

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | ***Over the last 2 weeks:*** |
|  |  | have you been bothered by little interest or pleasure in doing things? |
|  |  | have you been feeling down, hopeless or depressed? |

**If you answered YES to either question above, please do the PHQ-9 scale (separate page).**

**Update Your Family History:**

Has anything, new come up? (new illness among blood relatives)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any health problems and causes of death if applicable  I am adopted

Deceased? Age Medical Problems

Mother \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU EXPERIENCING ANY OF THE FOLLOWING (PLEASE CIRCLE):**

**General symptoms:** fever, weight loss, extreme fatigue   
**Eyes:** double vision, sudden loss of vision

**Ears, nose, mouth and throat:** sore throat, runny nose, ear pain

**Cardiovascular:** chest pain, palpitations

**Respiratory:** cough, wheezing, shortness of breath, can’t climb stairs or walk 1 block

**Gastrointestinal**: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools   
**Genitourinary:** frequent or painful urination, urine leakage, bloody urine, problems with sex or interest in sex,

**MEN ONLY**: impotence (problems with erections), slow stream, weak stream, urinating more than once per night "

**WOMEN ONLY**: irregular menstrual periods, vaginal bleeding after menopause, past abnormal Pap smear, hot flashes, birth control needs

**Last Menstrual Period was: (approximate date)**\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin:** rash, changing mole

**Sleep**: snoring; difficulty sleeping, stop breathing during sleep, worry about sleep apnea

**Neurological:** headache, persistent weakness or numbness on one side of the body, falling   
**Musculoskeletal:** joint pain, muscle weakness

**Psychiatric:** depression, anxiety, suicidal thoughts

**Endocrine:** excessive thirst, cold or heat intolerance, breast mass

**Hematologic:** unusual bruising or bleeding, enlarged lymph nodes

**Allergic:** hayfever

\_\_I am not having any of the above problems.

Please identify any issues above which are **new** or that you specifically want to address.

**Birth control method** (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications:** Do you have any trouble taking any of your medications? \_\_\_Yes \_\_\_No

If so, what sort of trouble: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**RISK FACTORS**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| **Tobacco Status:**  *Within a year of quitting your risk of heart attack drops by 50%. Ask us for help to quit using tobacco. In addition some people are able to quit with the help of the Maine Quit Line: 1-800-207-1230* | Do you now use tobacco? |  |  |
| If yes: what type and how much? | | |
| **Alcohol Use:**  *Men who drink 5 or more drinks in a day or 15 or more drinks/week are at risk of a drinking problem. Women who drink 4 or more drinks in a day or 8 or more drinks/week are at risk of a drinking problem.* | Do drink alcohol? |  |  |
| If yes: how much and how often? | | |
| **Drug Use:** | Have you used marijuana or any other "street" drugs in the last year? (Include using other people's prescription drugs; or using heroin or opioids) |  |  |
| **Controlled Substances:** | Do you take prescribed controlled medicines such as narcotics, stimulants or tranquilizers? |  |  |
| **Exercise History:**  *30 minutes walking most days can reduce the risk* of a *heart attack by 30%.* | If no, What type of exercise do you do now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How many times a week? (days)\_\_\_\_\_\_\_\_\_\_\_\_  How many minutes per day?\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Nutrition**

Are you on a special diet? YES NO

If so, circle all the diets you follow: Diabetic Low-Salt Low-Fat Low-Carb No-Meat No-Eggs No-Fish Vegetarian Vegan Mediterranean Paleo Gluten-Free Dairy-Free Nut-Free Refined Sugar-Free Weight-Watchers

Other/explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many servings of the following do you eat in an AVERAGE DAY?

**(serving size)**

-Fruits and vegetables (no potatoes/beans) \_\_\_\_\_\_ servings (=1 cup raw,1/2 cup cooked)

-High fiber or whole grain foods \_\_\_\_\_\_ servings (=1 slice 100% wholegrain,1/2 cup cereal/pasta)

-Fried or high-fat foods \_\_\_\_\_\_ servings (=size of palm of your hand)

-Sugar-sweetened (not diet) beverages \_\_\_\_\_\_ servings (= 8 ounces or 1 cup)

In the last 12 months:

- we worried our food would run out before we got money to buy more? YES NO

- the food we bought just didn't last, and we didn't have the money to buy more? YES NO