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Annual Wellness Visit Questionnaire

To ensure optimal care coordination, please list all providers you see on a regular basis.

Providers involved in your Healthcare	Specialty
Eye Doctor:	

Medical Devices and Durable Medical Equipment- check all that apply

☐ None
☐ Implantable cardioverter- defibrillator
☐ Insulin Pump
☐ Medication Pump
☐ Pacemaker
☐ Other:

☐ Oxygen Therapy
☐ Walker
☐ Wheelchair
☐ Bed (hospital)
☐ CPAP

☐ Spirometry
☐ Splint
☐ Immobilizer
☐ Commode
☐ CGM

Diagnostic Screenings

Have you had a colonoscopy? ☐ Yes ☐ No
If yes, where was your colonoscopy performed? _____
Women- have you had a mammogram? ☐ Yes ☐ No
If yes, where was your mammogram performed? _____
Have you had a Dexa Scan performed? ☐ Yes ☐ No
If yes, where was your Dexa Scan performed? _____

Sleep

Do you snore loudly? ☐ Yes ☐ No
Do you often feel tired, fatigued, or sleepy during daytime? ☐ Yes ☐ No
Has anyone observed you stop breathing while you're sleeping? ☐ Yes ☐ No
Have you or are you being treated for high blood pressure? ☐ Yes ☐ No

Alcohol Use History

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No
If yes, how often did you have a drink containing alcohol in the past year?
☐ 1-2 times per year ☐ 1-2 times per month ☐ 1-2 times per week ☐ 3-5 times a week
☐ Daily ☐ Several times a day
If yes, how many drinks did you have on a typical day when you were drinking in the past year?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

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If yes, how often did you have six or more drinks on one occasion in the past year?
☐ never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or almost daily

Tobacco Use History

Have you or do you use smoking tobacco?
☐ Never ☐ Current ☐ Former
If former or current smoker, how many cigarettes per day average during time you smoked?
#____
How many years have you or did you smoke?
Age Started ___ Age Stopped ____ #____
Have you or do you use smokeless tobacco?
☐ Never ☐ Current ☐ Former
Have you or do you use electronic Cigarettes (Vaping)?
☐ Never ☐ Current ☐ Former
Have you or do you use Illicit Substances?
☐ Never ☐ Current ☐ Former

Health Risk Assessment

Are there hazards in your house that might hurt you?. . . . . ☐ No ☐ Yes
Have you been given any information to help you with hazards
in your house that might hurt you?. . . . . ☐ No ☐ Yes
Have you fallen in the past year?. . . . . ☐ No ☐ Yes
Are you worried you might fall?. . . . . ☐ No ☐ Yes
Do you use a cane or a walker?. . . . . ☐ No ☐ Yes
Do you need someone to help you get up in the morning?. . . . . ☐ No ☐ Yes
In the past four weeks, have you fallen or felt dizzy when standing up?. . . ☐ No ☐ Yes
Because of any health problems, do you need the help of
another person with your personal care needs such as eating,
bathing, dressing, or getting around the house?. . . . . ☐ No ☐ Yes
Do you have trouble consistently taking or remembering to take all of
your medications as prescribed?. . . . . ☐ No ☐ Yes
Can you get to places out of walking distance without help?. . . . . ☐ No ☐ Yes
(For example, can you travel alone or drive your own vehicle?)
Can you go shopping for groceries or clothes without help?. . . . . ☐ No ☐ Yes
Can you prepare your own meals?. . . . . ☐ No ☐ Yes
Can you do your housework without help?. . . . . ☐ No ☐ Yes
Can you manage your own money without help?. . . . . ☐ No ☐ Yes

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Can you keep track of your own medications without help?. . . . . ☐ No ☐ Yes
Have you been given any information to help with keeping track of your medications?. . . . . ☐ No ☐ Yes
During the past four weeks, how would you rate your general health?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

During the past four weeks, how much bodily pain have you generally had?
☐ No pain ☐ Very mild pain ☐ Mild pain ☐ Moderate pain ☐ Severe Pain

During the past four weeks, how have things been going for you?
☐ Very well ☐ Pretty well ☐ Good and bad parts about equal ☐ Pretty bad ☐ Very bad

During the past four weeks, was someone available to help you if you needed and wanted help?
☐ Yes, as much as I wanted ☐ Yes, quite a bit ☐ Yes, some ☐ Yes, a little ☐ No, not at all

During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

During the past four weeks, how often have you had trouble eating well?
☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

During the past four weeks, how often have you had teeth or denture problems?
☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

During the past four weeks, how often have you had problems using the telephone?
☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

During the past four weeks, how often have you been bothered by sexual problems?
☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Are you having difficulties driving your vehicle?
☐ Not applicable, I do not use a car ☐ No ☐ Sometimes ☐ Yes, often

Do you always wear your seat belt when you are in a vehicle?
☐ I always fasten my seat belt ☐ I occasionally fasten my seat belt ☐ I never fasten my seat belt

How confident are you that you can control and manage most of your health problems?
☐ I do not have any health problems ☐ Very Confident ☐ Somewhat Confident ☐ Not Very Confident

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Depression Screen

How often have you been bothered by the below symptoms over the last **2 weeks**?

Little interest, pleasure in Doing things	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
Feeling down, depressed, 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 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	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
Trouble concentrating	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
Moving or speaking slowly	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
Thoughts better off dead or hurting self	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
Difficulty at work, home, or getting along with others	☐ Not difficult at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

Function Screen

Indicate a level of assistance for each activity of daily living:

Bathing:	☐ Independent	☐ Requires Assistance	☐ Dependent
Dressing:	☐ Independent	☐ Requires Assistance	☐ Dependent
Toileting:	☐ Independent	☐ Requires Assistance	☐ Dependent
Transferring Bed or Chair:	☐ Independent	☐ Requires Assistance	☐ Dependent
Continence:	☐ Independent	☐ Requires Assistance	☐ Dependent
Feeding:	☐ Independent	☐ Requires Assistance	☐ Dependent

Advanced Directive

Do you have an Advanced Directive? . . . . . ☐ Yes ☐ No

If yes, what type? ☐ Organ/ Tissue Donation ☐ Living Will ☐ Medical Durable POA

* Please bring a copy for us to place on file

Do you wish to receive further information on Advanced Directives?. . . . . ☐ Yes ☐ No

Immunizations

Are you interested in a Shingles vaccine series?. . . . . ☐ Yes ☐ No

Are you interested in a Covid vaccine series?. . . . . ☐ Yes ☐ No

Are you interested in a RSV vaccine?. . . . . ☐ Yes ☐ No

Do you need to update you Tetanus or Pneumococcal vaccine?. . . . . ☐ Yes ☐ No

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Social Determinants of Health: PRAPARE Form

1. **Language spoken:** □ English □ Spanish □ Other:
2. **What is your housing situation today?**
   □ I have housing □ I do not have housing □ I choose not to answer this question
3. **Are you worried about losing your housing?**
   □ Yes □ No □ I choose not to answer this question
4. **How many family members, including yourself do you currently live with?**
5. **What is the highest level of school you have finished?**
   □ Less than a highschool degree □ High school diploma or GED
   □ More than highschool □ I choose not to answer this question
6. **What is your current work situation?**
   □ Unemployed and seeking work □ Full time work □ Part time or temporary work (e.g. student) □ I choose not to answer this question □ Other:
7. **In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?**
   □ Child care □ Clothing □ Food □ Medicine or any health care □ Phone
   □ Utilities □ I choose not to answer this question □ None □ Other
8. **Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?**
   □ Yes, kept from getting to medical appts/getting medications
   □ Other □ Yes, kept from non-medical meetings, work, or necessities
   □ No □ Patient unable to respond □ Patient declines to respond
9. **How often do you see or talk to people that you care about and feel close to? (For example talking to friends on the phone, visiting friends or family, going to church or club meetings.)**
   □ Less than once a week □ 1-2 times a week □ 3-5 times a week
   □ More than 5 times a week □ I choose not to answer this question
10. **Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?**
    □ Not at all □ A little bit □ Somewhat □ Quite a bit □ Very much
    □ I choose not to answer this question
11. **Do you feel physically and emotionally safe where you currently live?**
    □ Yes □ No □ Unsure □ I choose not to answer this question
12. **In the past year, have you been afraid of your partner or ex-partner?**
    □ Yes □ No □ Unsure □ I have not had a partner