Franciscan Healthcare

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

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? _____

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

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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?

☐ monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times per week ☐ 4 or more times a week

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

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

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

Health Risk Assessment

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

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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?

Trouble falling or staying asleep	☐ 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

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