TRIANGLE FAMILY MEDICINE

ANNUAL WELLNESS VISIT QUESTIONNAIRE

Patient Name: _____ DOB: _____

Advance Directive

Do you currently have this in place?			
Living will (documents that make your health care wishes known, also called Advance Directive)	YES	NO	Unknown/ Don't Recall
Durable Power of Attorney for Medical Affairs (someone to make medical decisions for you in the event that you are unable to)	YES	NO	Unknown/ Don't Recall

Lifestyle

In the past 7 days, how many days did you exercise? _____

On days when you exercised, for how long did you exercise (in minutes)? _____

How intense was your typical exercise?

- ☐ Light (stretching, slow walking)
- ☐ Moderate (brisk walk)
- ☐ Heavy (jogging, swimming)
- ☐ Very heavy (fast running, stair climbing)
- ☐ I am currently not exercising

In the past 7 days, how often did you eat 3 or more servings of fruits and vegetables in a day?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

In the past 7 days, how often did you eat 3 or more servings of high fiber or whole grain foods in a day?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

How would you describe the condition of your mouth and teeth, including false teeth or dentures?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

Tobacco Use: Do you currently use any tobacco products?.....YES NO

- ○ Smoker, currently #Packs/day: _____
- ○ Former smoker Quit Date: _____ #Packs/day: _____

Alcohol: Do you drink alcoholic beverages?.....YES NO

If yes, how many drinks do you have per week/month/year? _____

Mental Health

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than ½ the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having very little energy	0	1	2	3
Poor appetite or over-eating	0	1	2	3
Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
If yes to any problems, how difficult have those 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				

How often is stress a problem for you?

- Never/rarely
- Sometimes
- Often
- Always

How well do you handle the stress in your life?

- I'm usually able to cope effectively
- At times I have problems coping
- I often have problems coping

How often do you get the social and emotional support you need?

- Always
- Usually
- Sometimes
- Rarely
- Never

Have you experienced any memory issues or problems with thinking?.....YES NO

Have any concerns about your memory been raised by family members, friends, caretakers, or others?.....YES NO

Activities of Daily Living

In your present state of health, how much difficulty do you have with the following activities?

Preparing food and eating	I can do this by myself	I need some help to do it	I cannot do this; another person needs to do it for me
Bathing yourself	I can do this by myself	I need some help to do it	I cannot do this; another person needs to do it for me
Getting Dressed	I can do this by myself	I need some help to do it	I cannot do this; another person needs to do it for me
Moving around from place to place	I can do this by myself	I need some help to do it	I cannot do this; another person needs to do it for me
Using the toilet	I can do this by myself	I need some help to do it	I cannot do this; another person needs to do it for me
Shopping for personal items (like toiletries or medicines)	I can do this by myself	I need some help to do it	I cannot do this; another person needs to do it for me

Managing money (keeping track of expenses or paying bills)	I can do this by myself	I need some help to do it	I cannot do this; another person needs to do it for me
Doing light housework (washing dishes, straightening up, or light cleaning)	I can do this by myself	I need some help to do it	I cannot do this; another person needs to do it for me

Do you ever leak urine or stool?.....YES NO

Do you wear a liner, pad, or special underwear because of leakage?.....YES NO

How often did you miss taking one or more of your medications in the last 2 weeks?

- ☐ Almost never
- ☐ Occasionally
- ☐ Frequently

Home Safety

Do you always fasten your seatbelt when you are in the car?.....YES NO

Do you have working smoke detectors in your home?.....YES NO

Fall Risk Assessment

Have you fallen 2 or more times in the last year?	YES	NO
Do you have difficulty with dizziness or problems with balance?	YES	NO
Do you avoid doing things due to the fear of falling?	YES	NO
Do you have things in your house which might cause you to fall?	YES	NO

Screenings

Have you had a colonoscopy in the last 10 years?	YES	NO
Females: Have you had a mammogram this year?	YES	NO
Females: Have you had a pelvic exam in the past 2 years?	YES	NO
Males: Have you had a prostate screening this year?	YES	NO
Have you had a flu vaccine this year?	YES	NO
Have you had a Zoster (shingles) vaccine?	YES	NO
Have you had a pneumonia vaccine since you turned 65?	YES	NO

Other Treating Physicians: As your Primary Care Provider, it is our job to make sure we keep current with your other physicians and care teams. Please list any other providers below. (Ex: Eye doctor, dermatologist, OB/GYN)

Name: _____ Name: _____
Specialty: _____ Specialty: _____

Name: _____ Name: _____
Specialty: _____ Specialty: _____

Name: _____ Name: _____
Specialty: _____ Specialty: _____

Name: _____ Name: _____
Specialty: _____ Specialty: _____