BLOSSOMWOOD MEDICAL

WALK + IN CLINIC

PRIMARY CARE FOR ADULTS

Annual Wellness Visit Questionnaire

Please fill out this form in its entirety to the best of your ability. Completion of the form will help the appointment progress faster and more effectively.

Name: ____ Date of Birth:____________

Family History

Please check whether any member of your family has suffered from any of the following:

	Father	Mother	Children	Siblings	Grandparents
Hypertension	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes (Type I or II)	☐	☐	☐	☐	☐
High Lipids	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Other: ____________________	☐	☐	☐	☐	☐

General Assessment

What is your height? ______ feet ______ inches

What is your weight? _______ pounds

Have you had the flu vaccine this year? Yes No

Are you planning on getting one this year? Yes No

When was the last time you had a (answer only those that apply):

Pneumonia vaccine?

☐ In the last year ☐ In the last 2-4 years ☐ In the last 5 years

☐ In the last 10 years ☐ Never

Shingles vaccine?

☐ In the last year ☐ In the last 2-4 years ☐ In the last 5 years

☐ In the last 10 years ☐ Never

Breast cancer screening (Mammogram)?

- ☐ In the last year
- ☐ In the last 2-4 years
- ☐ In the last 5 years
- ☐ In the last 10 years
- ☐ Never

Colorectal cancer screening (Colonoscopy)?

- ☐ In the last year
- ☐ In the last 2-4 years
- ☐ In the last 5 years
- ☐ In the last 10 years
- ☐ Never

Cervical cancer screening (PAP) Smear)?

- ☐ In the last year
- ☐ In the last 2-4 years
- ☐ In the last 5 years
- ☐ In the last 10 years
- ☐ Never

Please circle the number on the pain scale that addresses your overall pain throughout your daily life:

(none) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Do you have an Advanced Directive/Living Will on file with us? Yes No

How often do you exercise?

- ☐ Never
- ☐ 1-2 times/week
- ☐ 2-3 times/week
- ☐ >3 times/week

How does your current physical health compare to last year?

- ☐ Same
- ☐ Better
- ☐ Worse

How does your current mental health compare to last year?

- ☐ Same
- ☐ Better
- ☐ Worse

In the past year, have you fallen or been injured from a fall? Yes No

If yes, how many? ______

Have you recently lost weight without trying? Yes No

If yes, how much? ______ pounds within the past ______ months

What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

How do you live?

- ☐ Alone
- ☐ Spouse
- ☐ Institutional
- ☐ Family
- ☐ Other: ____

Do you have any financial concerns? Yes No

What is the highest grade or level of school that you completed?

- ☐ 8th grade or less
- ☐ Some high school (not a graduate)
- ☐ High school graduate/GED
- ☐ Some college/2 year degree
- ☐ 4 year college degree
- ☐ More than a 4 year college degree

Depression Screening

Over the past 2 weeks, have you been bothered by feeling down, depressed, or hopeless? Yes No

Over the past 2 weeks, have you often been bothered by little interest or pleasure in doing things? Yes No

Medication and Drug Review

Please remember to bring a detailed list of all of your medications, or the bottles of your medications with you to your appointment!!

Over the past 2 weeks, were there any days that you didn't take your medicine as prescribed? Yes No

How often do you miss doses of your medicine?

- ☐ Never
- ☐ A few times/year
- ☐ A few times/month
- ☐ A few times/week

Which factor keeps you from taking your medicine as directed?

- ☐ Forgetfulness
- ☐ Side Effects
- ☐ Cost
- ☐ Do not understand the directions
- ☐ Do not understand what the medication is for
- ☐ Do not think the medication is helping
- ☐ Do not think the medication is necessary
- ☐ Other: ______________________________

Have you ever used tobacco products?

Current Former Never E-cigs

What type? ____________________ Years used? ____________

How much? _________ # packs per day

Are you interested in quitting smoking/tobacco use? Yes No

On average, how many alcoholic drinks do you have a day? ________________

Have you had more than 4-5 alcoholic drinks in a day? Yes No

Do you use/Have you ever used any recreational drugs? Yes No

Are you allergic to any medications? Yes No

If yes, please list them: ____

____

Health Review

Would you consider yourself to be frail or in poor health? Yes No

Because of your health or physical condition, do you have difficulty:

Dressing yourself?	Yes	No
Bathing/showering or grooming yourself?	Yes	No
Using the toilet alone?	Yes	No
Getting out of a chair or bed?	Yes	No
Walking across the room (use of cane or walker is OK)?	Yes	No
Walking a quarter of a mile (use of cane or walker is OK)?	Yes	No
Stooping, crouching or kneeling?	Yes	No
Lifting or carrying objects as heavy as 10 pounds?	Yes	No
Handling/grasping small objects, such as a pencil?	Yes	No
Feeding yourself or swallowing food?	Yes	No
Driving or using public transportation?	Yes	No
Shopping for personal items (like toilet items or medicines)?	Yes	No
Managing money (keeping track of expenses/paying bills)?	Yes	No
Doing light housework (washing dishes/straightening up)?	Yes	No
Preparing meals?	Yes	No
Moving to different location (from bed to chair)?	Yes	No

Do you need to have the use of a device to help you move around (wheelchair, walker, cane, etc)? Yes No

If yes, what do you use? ____

How often? ☐ Going out ☐ Around the house ☐ Both

Do you require glasses/contacts for routine vision? Yes No

If you have vision problems, does the trouble with your vision make it difficult for you to watch TV, play cards, read your medication bottles, or participate in other activities? Yes No

Do you currently have any problems hearing? Yes No

If you have hearing problems, do you find it difficult to follow a conversation in a noisy restaurant or crowded room? Yes No

Do you feel people are mumbling/not speaking clearly? Yes No

Do you experience ringing or noises in your ears? Yes No

Do you hear better with one ear than the other? Yes No

If yes, which one? _______________

Do you wear hearing aids? Yes No

Place of Residence- Home/ Assisted Living/ Memory Care/ Nursing Home:

Do you have rails in your home? Yes No

Do you have locks on your doors? Yes No

Do you have scatter/ area rugs? Yes No

Do you have a list of emergency numbers? Yes No

Do you have night lights in your home? Yes No

Do you have guns in the home? Yes No

Consulting Physicians

Please list all other physicians that are currently providing health care for you:

Physician: ______________________________________ Type: ____________________

Physician: ______________________________________ Type: ____________________

Physician: ______________________________________ Type: ____________________

Physician: ______________________________________ Type: ____________________

Physician: ______________________________________ Type: ____________________

Physician: ______________________________________ Type: ____________________

Name of Eye Doctor: ____

Date of last eye exam: _________________