WARREN CLINIC

ANNUAL WELLNESS VISIT QUESTIONNAIRE

O Initial Preventive Physical Exam (Welcome to Medicare Physical)	O Initial annual wellness visit	O Subsequent annual wellness visit	Date of Wellness Visit	Time of Wellness Visit
Patient Name		Date of Birth		Age

This is a paper work visit and NOT a Physical Exam
The Wellness Exam is meant to identify your health risks and help you form a plan to reduce them.

PLEASE COMPLETE THIS ENTIRE PACKET
and
BRING IT AND A LIST OF ALL YOUR MEDICATIONS WITH YOU TO YOUR WELLNESS VISIT

This service is covered 100% by Medicare and will not get applied to your deductible.
However, some testing programs and lab services may be subject to Medicare co-pays and deductibles.

SPECIALISTS, CAREGIVERS, & HEALTH CARE SERVICES

(Examples: eye doctors, cardiologists, home health nursing, assistive devices (canes, walkers, wheelchairs), oxygen, CPAP, ostomy supplies)

Specialty Physician (i.e. cardiologist, eye doctor)	Phone Number	Service Company (i.e. oxygen, CPAP)	Phone Number	Caregiver Name (i.e. Home Health)	Phone Number

DEPRESSION SCREENING

How have you felt over the past week--

--Are you basically satisfied with your life?..... ☐ Yes ☐ No
--Have you dropped many of your activities and interests?..... ☐ Yes ☐ No
--Do you feel that your life is empty?..... ☐ Yes ☐ No
--Do you often get bored?..... ☐ Yes ☐ No
--Are you in good spirits most of time?..... ☐ Yes ☐ No
--Are you afraid that something bad is going to happen to you?..... ☐ Yes ☐ No
--Do you feel happy most of the time?..... ☐ Yes ☐ No
--Do you often feel helpless?..... ☐ Yes ☐ No
--Do you prefer to stay at home, rather than going out and doing new things?..... ☐ Yes ☐ No
--Do you feel you have more problems with memory than most?..... ☐ Yes ☐ No
--Do you think it is wonderful to be alive now?..... ☐ Yes ☐ No
--Do you feel worthless with the way you are now?..... ☐ Yes ☐ No
--Do you feel full of energy?..... ☐ Yes ☐ No
--Do you feel that your situation is hopeless?..... ☐ Yes ☐ No
--Do you think that most people are better off than you are?..... ☐ Yes ☐ No

HOME SAFETY SCREENING

Do you have throwrugs on hardwood floors in your house?..... ☐ Yes ☐ No
Do you have pets that stay indoors?..... ☐ Yes ☐ No
Does your house have smoke alarms and carbon monoxide detectors in good working order?..... ☐ Yes ☐ No
Does your bathtub contain a safety measure such as a rubber mat or strips?..... ☐ Yes ☐ No
Is the area in front of your bathtub carpeted or protected by a bathmat with rubber backing?..... ☐ Yes ☐ No
Do you have night lights in your house?..... ☐ Yes ☐ No
Do you have loose or frayed cords or overloaded electrical sockets in your house?..... ☐ Yes ☐ No
Do you unplug household appliances when not in use?..... ☐ Yes ☐ No
Do you keep medicines in a safe place and have their directions clearly labeled?..... ☐ Yes ☐ No
Do you keep knives and other sharp objects put away in a safe place?..... ☐ Yes ☐ No
Do you keep poisons, chemical or other toxic substances put away in a safe place?..... ☐ Yes ☐ No
Do you have furniture (i.e. coffee table) with sharp corners, or a rickety chair, that could cause injury?..... ☐ Yes ☐ No

FUNCTIONAL ACTIVITIES SCREENING

Can you get out of bed by yourself? ☐ Yes ☐ No
Can you dress yourself without help? ☐ Yes ☐ No
Can you prepare your own meals? ☐ Yes ☐ No
Do you do your own shopping? ☐ Yes ☐ No
Do you write checks and pay your own bills? ☐ Yes ☐ No
Do you drive or have other means of transportation for traveling outside your neighborhood? ☐ Yes ☐ No
Are you able to keep track of appointments and family occasions? ☐ Yes ☐ No
Are you able to take medicine according to directions, dosing, etc.? ☐ Yes ☐ No
Are you able to keep track of current events? ☐ Yes ☐ No
Are you still able to play games of skill that you enjoy or work on a favorite hobby? ☐ Yes ☐ No

FALL RISK SCREENING

Do you notice numbness in your feet? ☐ Yes ☐ No
Do your steps feel "heavy" when you walk? ☐ Yes ☐ No
Do you ever feel light-headed upon rising from a seated position? ☐ Yes ☐ No
When walking, can you start and stop without difficulty? ☐ Yes ☐ No
Do you have trouble getting out of a chair? ☐ Yes ☐ No
Do you have any kind of difficulty when walking? ☐ Yes ☐ No
Do you ever lose your balance with movements such as bending over, turning around, etc.? ☐ Yes ☐ No
Have you ever fallen in the past? ☐ Yes ☐ No

HEARING LOSS SCREENING

Do you have a problem hearing over the telephone? ☐ Yes ☐ No
Do you have trouble following the conversation when two or more people talk at the same time? ☐ Yes ☐ No
Do people complain that you turn the TV or radio volume up too high? ☐ Yes ☐ No
Do you have to strain to understand conversations? ☐ Yes ☐ No
Do you have trouble hearing in a noisy background (i.e. party, movie theater)? ☐ Yes ☐ No
Do you find yourself asking people to repeat themselves? ☐ Yes ☐ No
Do many people you talk to seem to mumble or not speak clearly? ☐ Yes ☐ No
Do you misunderstand what others are saying and respond inappropriately? ☐ Yes ☐ No
Do you have trouble understanding the speech of women and children? ☐ Yes ☐ No
Do people get annoyed because you misunderstand what they say? ☐ Yes ☐ No

URINARY INCONTENENCE SCREENING

DO YOU LEAK URINE (EVEN SMALL DROPS)

--when you cough or sneeze? ☐ Yes ☐ No
--when you bend down or lift? ☐ Yes ☐ No
--when you walk quickly, jog, or exercise? ☐ Yes ☐ No
--while you are undressing to use the toilet? ☐ Yes ☐ No

Do you get such a strong urge to urinate that you leak urine before you reach the toilet? ☐ Yes ☐ No
Do you have to rush to the bathroom because you get a sudden, strong need to urinate? ☐ Yes ☐ No

HAS LEAKAGE AFFECTED YOUR ABILITY TO:

--do household chores? ☐ Yes ☐ No
--participate in physical recreation (i.e. walking, swimming, exercise)? ☐ Yes ☐ No
--participate in entertainment activities (i.e. movies, concerts)? ☐ Yes ☐ No
--travel by car more than 30 minutes from home? ☐ Yes ☐ No
--participate in social activities outside your house? ☐ Yes ☐ No

Does leakage have you feeling frustrated, nervous, or depressed? ☐ Yes ☐ No

OSTEOPOROSIS RISK SCREENING

Do you have documented OSTEOPOROSIS or OSTEOPENIA? ☐ Yes ☐ No
Are you older than 65 years of age? ☐ Yes ☐ No
Have you ever had a Bone Densitometry? ☐ Yes ☐ No
Do you take or have you ever been on cortisone, prednisone, or other steroids for greater than 3 months during your life? ☐ Yes ☐ No
Are you thin, small boned, or weigh less than 127 pounds? ☐ Yes ☐ No
Do you drink alcohol beverages or smoke? ☐ Yes ☐ No
Does anyone in your immediate family have osteoporosis? ☐ Yes ☐ No
Do you live an inactive lifestyle (lack of exercise)? ☐ Yes ☐ No

MEDICATIONS—Are you currently of have you ever taken…

☐ Blood thinners (i.e. Coumadin) ☐ Cancer (i.e. Chemo, Radiation) ☐ Seizure (i.e. Dilantin)
☐ Rheumatism (i.e. Methotrexate) ☐ Water Pill (i.e. Furosemide)
☐ Thyroid (i.e. Synthroid, Levothyroid) ☐ Osteoporosis (i.e. Actonel, Boniva, Fosamax, Prolia, Reclast)

DISORDERS—Do you currently or have you ever had…

☐ Alcoholism ☐ Kidney Stones ☐ Cancer
☐ Malabsorption ☐ Eating Disorder ☐ Rheumatism
☐ Hyperparathyroidism ☐ Thyroid Disease

BONE/VERTEBRAL ABNORMALITIES

Do you have a backache, humped back (kyphosis), or back curvature (scoliosis)? ☐ Yes ☐ No
Do you have an abnormal posture? ☐ Yes ☐ No
Have you lost over 1 inch in height since age 25? ☐ Yes ☐ No
Have you had a compression fracture of the back? ☐ Yes ☐ No
Have you had hip replacement surgery? ☐ Yes ☐ No
Have you broken any bones without much effort or trauma? ☐ Yes ☐ No

****WOMEN ONLY****

Have you stopped having periods (post menopausal)? ☐ Yes ☐ No

If "Yes" to above question, please answer below

Did your periods stop before age 45? ☐ Yes ☐ No
Did you have your ovaries removed? ☐ Yes ☐ No
Are you experiencing hot flashes, sleeplessness, headaches, lack of concentration, vaginal dryness, or decreased libido? ☐ Yes ☐ No
Are you on Estrogen? ☐ Yes ☐ No

PROSTATE DISORDER RISK SCREENING **(MEN ONLY)**

	Not At All	Less than 1-5 times	Less than ½ time	About ½ time	More than ½ time	Almost Always
Over the past month…						
--how often have you had a sensation of not emptying your bladder completely after you finished urinating?	☐	☐	☐	☐	☐	☐
--how often have you had to urinate again less than two hours after you finished urinating?	☐	☐	☐	☐	☐	☐
--how often have you stopped and started again several times when you urinated?	☐	☐	☐	☐	☐	☐
--how often have you found it difficult to postpone urination?	☐	☐	☐	☐	☐	☐
--how often have you had to push or strain to being urination?	☐	☐	☐	☐	☐	☐
---how often have you had a weak urinary stream?	☐	☐	☐	☐	☐	☐

Over the past month, typically, how many times did you get up to urinate during the night? ☐ None ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5+ times