

ANNUAL WELLNESS FORM

(To be completed by the patient, family member, or caregiver prior to seeing the doctor)

Name:	Date of Birth	Date	
CHRONIC Medical Problem	Date of Onset	Complications	

Family History (check or enter "x" if a condition applies to that relative)

Father	Mother	Sibling(s)	Grandparents	Other

PATIENT CHECKLIST

1. During <u>the past 4 weeks</u>, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, or sad? **Check one (place "x"):**

Not at all	Slightly	Moderately	Quite a bit	Extremely
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2. During the <u>past 4 weeks</u>, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups? **Check one (place "x")**

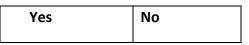
Not at all	Slightly	Moderately	Quite a bit	Extremely
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*(physician: Administer PHQ-9 if answer is in shaded area for 1 or 2)

3. Are you currently taking any prescription medications for pain? Check one (place "x")

Yes	No
res	Νο

4. During the last 12 months, have you fallen more than 2 times? Check one (place "x")



5. During the last 12 months, have you had a fall that resulted in an injury? Check one (place "x")

Yes	No

6. Do you think that you are at high risk for falling? Check one (place "x")



*(physician: Administer fall risk assessment if answer is "yes" for 3, 4, or 5)

7. Do you smoke or use tobacco products? Check one (enter "x")

No, I have never smoked/used tobacco	No, I am a former smoker/tobacco user
Yes, I smoke/use tobacco and want to quit	Yes, I smoke/use tobacco and do not want to quit

(physician: provide cessation counseling if the answer is "yes")

8. In the <u>past 4 weeks</u>, how many drinks of wine, beer or other alcoholic beverages did you have? **Check one** (enter "x")

10 or more per week	6-9 per week	2-5 per week	1 drink or less per week	none
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9. During the <u>past 4 weeks</u>, the hardest physical activity you could do for at least 2 minutes was? Check one (enter "x")

Very Heavy	Heavy	Moderate	Light	Very light

10. Do you exercise at least 20 minutes, 3 or more days per week? Check one (enter "x")

Yes, most of the time	Yes, some of the time	No, I do not exercise this much

11. During the past 4 weeks, how would you rate your health? Check one (enter "x")

Excellent Very Good	Good	Fair	Poor
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12. During the past 4 weeks, how much bodily pain have you had? Check one (enter "x")

No Pain Very Mild Pain	Mild Pain	Moderate Pain	Severe Pain
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13. How often in the past 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Often	Always
Fall or dizzy when standing up				
Sexual problems				
Difficulty eating well				
Teeth or Dentures				
Problems using the telephone				
Tired or Fatigued				

14. How often do you have trouble taking medicines the way that you have been told to take them? Checkone

I do not have to take	I always take them as	I sometimes take them	I seldom take them as
medicine	prescribed	as prescribed	prescribed

15. How confident are you that you can control and manage most of your health problems?

Very confident Somewhat confident	Not very confident	I do not have health problems
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16. Are you having difficulties driving your car?

Yes, often	Sometimes	No	I do not drive

17. During the past 4 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
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Annual Medicare wellness visit Med/Health hx

Travel alone by bus, taxi, or drive your own car?	
Shop for groceries or clothing without help?	
Prepare your own meals?	
Do your own housework without help?	
Eating, bathing, dressing, or getting around your home	

19. Do you have urinary incontinence?

I have reviewed the above information provided to me by the patient.

Patient Signature

Physician Signature

Other notes/observations:

Date

Date

Yes

No

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:		DATE:		
Over the last 2 weeks, how often have you been				
bothered by any of the following problems? (use " \checkmark " to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	-	•	F
(Healthcare professional: For interpretation of TOTA please refer to accompanying scoring card).	AL, TOTAL:			
10. If you checked off any problems, how difficult		Not diffi	cult at all	
have these problems made it for you to do		Somewl	nat difficult	
your work, take care of things at home, or get		Very difficult		
along with other people?	Extremely difficult			

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