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
Hypertension	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐

PATIENT CHECKLIST

1. During the past 4 weeks, 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

2. During the past 4 weeks, 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

***(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

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

Yes	No

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")**

Yes	No

***(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 past 4 weeks, 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

9. During the past 4 weeks, 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

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

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? **Check one**

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

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

18. Can you do the following **without help**? **Yes** **No**

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? **Yes** **No**

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

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

Other notes/observations:

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 "✓" 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	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these 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 _____

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