The Christ Hospital™ Health Network

Primary Care
ANNUAL WELLNESS VISIT QUESTIONNAIRE

Patient Name _____ **Date of Birth** _____

Please complete this checklist before your Medicare Wellness Visit.

Please list any changes to your **Medical**, **Surgical**, and **Family** history since your last visit:

_____

_____

_____

Have you been hospitalized since we last saw you? ❑ Yes ❑ No

If yes, provide details:

Date: _____

Reason: _____

Name of Hospital: _____

Have you see a healthcare provider outside of our clinic since we last saw you? ❑ Yes ❑ No

If yes, provide details:

Date of Visit: _____ Provider Name _____

Other Information: _____

In the past 2 weeks, how often have you felt bothered by any of the following problems?

Little interest or pleasure in doing things?

❑ Not at all

❑ Several days (if selected, answer questions on pg. 2)

❑ More than half of the days (if selected, answer questions on pg. 2)

❑ Nearly every day (if selected, answer questions on pg. 2)

Feeling down, depressed or hopeless?

❑ Not at all

❑ Several days (if selected, answer questions on pg. 2)

❑ More than half of the days (if selected, answer questions on pg. 2)

❑ Nearly every day (if selected, answer questions on pg. 2)

Patient Name _____ **Date of Birth** _____

Answer these questions only if you answered "Several days, more than half of the days or nearly every day" in the previous section on page 1.

Trouble falling or staying asleep, or sleeping too much

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

Feeling tired or having little energy

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

Poor appetite or overeating

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

Feeling bad about yourself – or that you are a failure or have let yourself or your family down

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

Trouble concentrating on things, such as reading the newspaper or watching TV

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

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

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

Thoughts that you would be better off dead or of hurting yourself in some way

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

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

Patient Name _____ **Date of Birth** _____

In general how would you say your health is?

- ❑ Excellent
- ❑ Good
- ❑ Fair
- ❑ Poor

In general, how satisfied are you with your life?

- ❑ Very Satisfied
- ❑ Satisfied
- ❑ Dissatisfied
- ❑ Very Dissatisfied

In the past 7 days, how much pain have you felt?

- ❑ None
- ❑ Some
- ❑ A lot

Do you usually exercise at least 30 minutes or more; 4 days a week? ❑ Yes ❑ No

Do you usually eat a diet that has at least 4 servings of fruit, vegetables, includes whole grain and fiber and avoids other than the occasional servings of high fat foods? ❑ Yes ❑ No

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

- ❑ Excellent
- ❑ Good
- ❑ Poor

In a typical week, how much alcohol do you drink?

- ❑ None
- ❑ Two drinks per day or less (if selected answer question below)
- ❑ More than two drinks per day (if selected answer question below)

Do you ever have 5 or more alcoholic drinks on one occasion? ❑ Yes ❑ No

Do you always fasten your seatbelt when you are in a car? ❑ Yes ❑ No

Do you know where to locate and properly use a first aid kit and fire extinguisher in case of an emergency?
❑ Yes ❑ No

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet? ❑ Yes ❑ No

In the past 7 days, did you need help from others to take care of things such as laundry, housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medications?
❑ Yes ❑ No

In the past 7 days have you had any problems staying or falling asleep? ❑ Yes ❑ No

In the past 7 days have you had any problems with constipation? ❑ Yes ❑ No

Patient Name _____ **Date of Birth** _____

Have you fallen in the past year? ❑ Yes ❑ No

If yes, how many times in the past year? ❑ Once ❑ Two or more times

Do you feel unsteady when walking? ❑ Yes ❑ No

Does your home have rugs in the hallway? ❑ Yes ❑ No

Does your home have grab bars in the bathroom? ❑ Yes ❑ No

Does your home have handrails on the stairs? ❑ Yes ❑ No

Does your home have good lighting? ❑ Yes ❑ No

Do you or any of your friends or family members have concerns about your memory? ❑ Yes ❑ No

Do you have problems with your hearing? ❑ Yes ❑ No

Physician/Provider signature: _____ Date: _____