Northwest PRIMARY CARE

Annual Wellness Visit Questionnaire

Date: _____ Appointment Date & Time: _____

Name: _____ DOB:_____ ☐ Male ☐ Female

Physician Signature: _____

Hospitalization

Have you been hospitalized within the last year?
(Do not include pre-arranged surgery):

☐ YES
☐ NO

If Yes, please list date, where, and reason for hospitalization.

Social History

Do you use tobacco?

☐ YES How many packs/years? _____
☐ NO
☐ Previous Smoker

Do you use alcohol?

☐ YES
☐ NO
☐ Stopped drinking alcohol

Do you use "recreational drugs"?

☐ YES What do you use?_____
☐ NO
☐ Quit using drugs

Hearing

Check all that apply

☐ I use the TV and/or radio at high volume, when others do not.
☐ I have to strain to understand conversation.
☐ I am concerned about my hearing.
☐ I wear hearing aids.

Depression

Have you had feelings of hopelessness in the past 2 weeks?

☐ YES
☐ NO

Have you experienced loss of pleasure from doing your usual activities in the past 2 weeks?

☐ YES
☐ NO

ANNUAL WELLNESS VISIT

Fall Prevention

Have you fallen in the past year?

☐ YES
☐ NO

Do you use a walker or cane?

☐ YES
☐ NO

Do you have concerns about your balance?

☐ YES
☐ NO

Does your home have any of the following?

- Loose Rugs
- Stairs without hand rails
- Bathroom without hand rails
- Poor lighting

☐ YES
☐ NO

Exercise

Do you exercise?

☐ YES
☐ NO

If no, would you be interested in talking about adding exercise to your daily routine?

☐ YES
☐ NO

Bladder Control

Have you experienced urinary leakage in the last 6 months? **(Women Only)**

☐ YES
☐ NO

If Yes, would you like to discuss treatment options?

☐ YES
☐ NO

Family History (Blood Relatives)

Please provide any current or past medical concerns for each family member listed below, e.g., diabetes, heart attack, hypertension, cancer.

	Living/ Age	Deceased/ Age at Death	If deceased, list cause of death and all major health problems.
Father			
Mother			
Brothers and Sisters			
1			
2			
3			
4			
5			
Children			
1			
2			
3			
4			