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	Specialist Name

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? **Checkone**

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**

	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**

20. Have you had a chance to discuss and document your preferences for end-of-life care? **Yes** **No**

21. Do you have a DNR (do-not-resuscitate) on file with our office? **Yes** **No**

22 Do you have instructions on file for life saving care if you are unable to answer for yourself for life sustaining treatment? **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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