

ANNUAL WELLNESS

Name: _____ DOB: _____ Date: _____

Has anything changed in regard to your health in the past year? (*new illness, surgeries, new medication allergies or intolerances, etc.*)

Have there been any significant changes in your life in the past year such as *increased stress, new job, home, relationship, children, ill relatives, etc.*?

Have any of your blood relatives developed any new illnesses in the past year? If any blood relative has had cancer, please list their relation to you, what they had, and how old they were when diagnosed:

If you have had any vaccines in the past year, please list them & the approximate date(s):

What is your occupation: _____ Spouse's occupation: _____

If you have children, what are their names & ages? _____

Do you currently use tobacco? Yes No What kind(s)? Cigarettes Cigars Pipe Vape Chew

If yes, how much do you smoke (use) daily? _____

If no, have you ever used tobacco? Yes No What kind(s)? Cigarettes Cigars Pipe Vape Chew

If yes, how many packs per day did you smoke? _____ How many years did you smoke? _____ Year Quit _____

Any exposure to secondhand smoke (others smoking around you) currently or in the past? Yes No

If yes, please explain: _____

Do you currently use recreational drugs (like marijuana, etc)? Yes No

Do you wear a seatbelt? Yes No Occasionally

Do you exercise regularly? Yes No If yes, what do you do for exercise and how often? _____

Please describe your diet _____

What do you and your partner use for contraception (*if applicable*)? _____

Have you had a new sexual partner in the past year? Yes No

Would you like to be tested for HIV or other STDs? Yes No

Do you see a dentist at least once a year? Yes No

HEALTHCARE WISHES:

Do you already have a healthcare proxy or living will? Yes No Are you willing to be an organ donor? Yes No

Most healthy patients would like to be treated aggressively (CPR, respirator, ICU, etc) if they had a potentially curable condition. If you had a condition that had no chance of recovery, would you wish to remain on life support? Yes No Not Sure

If you were unable to make your own healthcare decisions (*for instance, you were in a coma from a car accident*), whom would you like us to ask about what your wishes would be? Please name one person and one alternate.

Name: _____ Phone No: _____ Relationship to You: _____

Name: _____ Phone No: _____ Relationship to You: _____

Please list any other physicians you are currently seeing:

<u>Name of Physician</u>	<u>Location</u>	<u>Reason</u>
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_____	_____	_____
_____	_____	_____

NAME: _____ DATE: _____

ANNUAL HEALTH SCREENINGS:

PHQ-9 Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems? (Please ✓ the appropriate box)	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off <u>any</u> problems listed above, 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? (Please circle your answer)	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

S: _____ Dx: _____

AUDIT-C Please circle your answers:	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times a month	2 - 3 times a week	4 or more times a week
How many standard drinks containing alcohol do you have on a typical day when you drink?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

S: _____ Dx: _____