WELLNESS FORM

Patient Name : _____

Date of Birth : _____

Diet & Exercise

1. What type of diet do you follow?	☐ Regular ☐ Specific _____ ☐ Vegetarian ☐ Carbohydrate ☐ Vegan ☐ Cardiac ☐ Gluten-Free ☐ Diabetic
2. How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?	
a. On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise?	
3. What types of physical activities do you participate in?	

Substance Use (12yrs +)

1. Do you or have you ever smoked tobacco?	☐ Never smoker (Skip to Question 2) ☐ Former smoker, quit date: _____ ☐ Current every day smoker ☐ Current some days smoker	
a. How many years have you smoked tobacco?		
b. At what age did you start smoking tobacco?		
c. How much tobacco do you smoke?	☐ None ☐ ½ pack per day ☐ 1 pack per week ☐ 1 pack per day ☐ 2 packs per week ☐ 2 packs per day ☐ ¼ pack per day ☐ 3+ packs per day	
2. Do you or have you ever used any other forms of tobacco or nicotine?	☐ Yes	☐ No (Skip to Question 3)
a. Do you or have you ever used e-cigarettes or vape?	☐ Never used electronic cigarettes ☐ Former user of electronic cigarettes ☐ Current user of electronic cigarettes	
b. How many years have you used e-cigarettes or vape?		
c. Do you or have you ever used smokeless tobacco?	☐ Never used smokeless tobacco ☐ Former smokeless tobacco user ☐ Current snuff user ☐ Currently chew tobacco ☐ Currently use moist powdered tobacco	

3. Do you consume alcohol?	☐ Yes	☐ No (Skip to Question 4)
a. How many times per week do you consume alcohol?	☐ Less than 1 time per week ☐ 1-2 times per week ☐ 3-4 times per week ☐ 5-7 times per week	
b. How many alcoholic drinks do you consume per day on average?		
c. How many years have you consumed alcohol?		
d. (WOMEN) How many days in the past year have you consumed 4 or more drinks?		
e. (MEN) How many days in the past year have you consumed 5 or more drinks?		
4. Do you use any illicit or recreational drugs?	☐ Yes	☐ No
a. Which illicit or recreational drugs have you used?		
b. Have you used IV drugs?	☐ Yes	☐ No
5. What is your level of caffeine consumption?	☐ None ☐ Occasional	☐ Moderate (1-2 /day) ☐ Heavy (3 or more)

Marriage & Sexuality

1. What is your relationship status?	☐ Married ☐ Single ☐ Divorced ☐ Other _____	☐ Separated ☐ Widowed ☐ Domestic Partner	
2. Are you sexually active?	☐ Yes	☐ No	
a. Do you use protection against sexually transmitted diseases?	☐ Always	☐ Usually	☐ No
b. Which type of protection is used?			
3. If you have children, how many children do you have?			
a. Where do they live?			

Education & Occupation

1. What is the highest grade or level of school you have completed or the highest degree you have received?		
2. Are you currently employed?	☐ Yes	☐ No
a. Who is your employer?		
b. What is your occupation?		

Advance Directive

1. Do you have an advance directive?	□ Yes	□ **No**
2. Do you have a medical power of attorney?	□ Yes	□ **No**

Home & Environment

1. Who do you live with?		
2. Have there been any changes to your family or social situation?	□ Yes	□ No
a. If so, what changes?		
3. Do you have any pets?	□ Yes	□ No
4. Do you have a working smoke and carbon monoxide detectors in your home?	□ Yes	□ **No**
5. Are you passively exposed to secondhand tobacco smoke?	□ Yes	□ No
6. Are there any guns present in your home?	□ Yes	□ No (skip to Question 7)
a. If so, how are they stored?		
7. Do you use sunscreen routinely?	□ Yes	□ No

Specialists

Please list all medical specialists you see regularly:		
Ex. Cardiology, Nephrology, Urology, Ortho, Rheumatology, Physical Therapy, Podiatry, etc		
Specialty	Provider Name	Facility/Clinic Name/Location

DME

Please list all medical devices you use:		
Ex. Wheelchair, walker, cane, prosthesis, CPAP, oxygen, etc		
Device	Provider for DME	Why?

Lifestyle

1. Do you use your seatbelt or car seat routinely?	□ Yes	□ **No**
2. Do you wear a helmet when biking?	□ Yes	□ **No**
3. When did you last see your dentist? *(month + year)*		
4. When did you last have your vision checked? *(month + year)*		
5. Are you able to bathe yourself, care for your own hygiene and dress yourself?	□ Yes	□ **No**
6. Are you able to care for your own health, manage and take your medicines on your own?	□ Yes	□ **No**
7. Are you able to do your own shopping and run your own errands?	□ Yes	□ **No**
8. Are you able to manage your money and finances?	□ Yes	□ **No**
9. Are you able to prepare your own food and feed yourself?	□ Yes	□ **No**
10. Are you able to use a telephone and computer?	□ Yes	□ **No**
11. Are you experiencing any physical, emotional, sexual, or financial abuse?	□ **Yes**	□ No
12. Do you feel safe at home?	□ Yes	□ **No**
13. Do you have adequate housing?	□ Yes	□ **No**
14. Do you have any difficulties driving?	□ **Yes**	□ No
15. Do you have any difficulties with eating, swallowing, or digestion?	□ **Yes**	□ No
16. Do you have any hearing difficulties?	□ **Yes**	□ No
17. Do you have any vision difficulties?	□ **Yes**	□ No
18. Do you have concerns with your memory or cognition?	□ **Yes**	□ No
19. Do you have emotional support – family, friends, neighbors, church, coworkers, etc	□ Yes	□ **No**
20. Do you have mobility or balance issues?	□ **Yes**	□ No
21. Have you fallen in the last year?	□ **Yes**	□ No
22. Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?	□ Not at all □ Only a little □ To some extent □ **Rather much** □ **Very much**	

23. Over the last 2 weeks, how often have you been bothered by the following problems?

(circle one)	Not at all	Several days	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3