SOUTH ISLAND MEDICAL
Primary & Immediate Care

Wellness 65+ Form 2021

Today's Date: _____

NAME: _____ Date of Birth: _____

Please list other medical specialists you see regularly:
Ex. Cardiology, Pulmonologist, Nephrologist (Kidney), Urologist, Orthopedist, Rheumatologist, Physical Therapist, Podiatrist, Chiropractor, Acupuncturist, Massage Therapist, Nutritionist, Naturopath, Dentist, Optometrist/Ophthalmologist, Neurologist, Gynecologist, Psychiatrist, Psychologist, Counselor, Oncologist.

Name	Facility/Clinic & City Phone #	Specialty

EMERGENCY CONTACTS

Name: _____ Relationship:_____ Phone #: _____

Name: _____ Relationship:_____ Phone #: _____

ADVANCED DIRECTIVES

Do you have a living will or healthcare directive? Y **N**

Do you have a DPOA (durable power of attorney) for healthcare? Y **N**

If yes, who is it? _____

VACCINES – Enter year (if known) of vaccinations you have had.

Tetanus (Td or TdaP) _____Influenza (Flu) _____

COVID _____ circle: *Moderna* *Pfizer* *J&J/Janssen*

Pneumococcal: (PPSV23) _____ (PCV13)_____

Shingles: Zostavax (newer 1-dose) _____ Shingrix (older 2-dose) _____

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HEALTH AND SAFETY QUESTIONS

Have you had any major changes in your life this past year? **Y** N

Please explain: _____

_____

Do you have any vision difficulties? **Y** N

Name and location of eye doctor (optometrist or ophthalmologist):

_____

Last visit: _____

Do you have any tooth or oral problems that interfere with eating? **Y** N

Do you wear dentures? **Y** N

Name and location of dentist: _____

Last visit: _____

Do you have any hearing difficulties? **Y** N Do you wear hearing aids? **Y** N

Do you have any speech difficulties? **Y** N

Do you have any Sleep pattern/difficulties? **Y** N

How many hours of sleep do you get every night? _____

Do you have any Urinary difficulties or incontinence? **Y** N

Do you have any Bowel difficulties? **Y** N

Do you have any difficulties walking? **Y** N

Have you fallen in the last year? **Y** N

Do you have any concentration or memory problems? **Y** N

Do you drive? Y **N** Do you think you are a safe driver? Y **N**

Do you feel safe at home? Y **N** Do you have adequate housing? Y **N**

Do you have sufficient heat? Y **N** Do you have sufficient food? Y **N**

Do you have working smoke and carbon monoxide detectors? Y **N**

If you have guns in the home are they secured/locked? Y **N** N/A

Do you regularly use seatbelts/helmets? Y **N**

Are you experiencing physical, emotional, financial or sexual abuse? **Y** N

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Circle or Mark with an X those things you CANNOT do on your own:

Bathing and hygiene self-care
Dressing
Shopping for groceries or clothing
Meal preparation and cleanup
Eating and Drinking
Taking medications
Health maintenance and management
Housework
Community mobility – getting around town
Managing money
Using technology and telephone
Care of pets
Care of others (including supervising caregivers)

MEDICAL QUESTIONS

Please list **ALL MEDICAL DEVICES** you use.
Ex. Wheelchair, walker, cane, prosthesis, CPAP, oxygen, TENS machine

Device	***Details***	***Why?***

Last Colon Cancer Screening: Colonoscopy Cologard FIT test
Date:_____ Result: _____

Last Bone Density Exam (DEXA): _____

Results: Normal **Osteopenia** **Osteoperosis** **Don't Know**

Do you take Vitamin D? Y **N** What dose & how often?_____

Do you take Calcium? Y **N** What dose & how often?_____

Do you take any other medicine for bone health/strength? **Y** N

What, how much, & how often?_____

Have you ever broke a bone? **Y** N Explain:_____

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PERSONAL/SOCIAL QUESTIONS

Who do you live with? _____

Marital Status: Single Married Divorced Widow/Widower

Spouse's Name: _____How many children do you have? _____ Do any live nearby? **Y** **N**

Do you have any pets? **Y** **N** Details: _____

_____

Do you have a support circle? Family, friends, work, volunteer, church, etc… **Y** **N**

What are your hobbies, what do you do in your spare time? _____

_____

During the past 2 weeks:
Have you been bothered by feeling down, depressed or hopeless? **Y** **N**

Have you been bothered by little interest or pleasure in doing things? **Y** N

Circle the type of diet you follow: Regular Vegetarian Vegan Gluten Free Mediterranean Keto

Other: _____

Do you eat 2 or more meals daily? **Y** **N**

How many fruits and vegetables do you eat daily? _____

How many days per week to you do moderate exercise, like gardening or

going for a brisk walk? _____

What type of exercise do you do and how often? _____

Do you drink alcohol? **Y** N

What type & how much/often? (ex. 1 glass wine nightly, 6 pack every.

Saturday) _____

Do you use tobacco? **Y** N

What type (smoking, vaping, chewing, snuff) and how much/often? (ex. 1/2 pack per day, tin of chew weekly):_____

_____

Do you use marijuana products ? **Y** N

What type (CBD or THC, topical, edible, vape, smoke, pills) and how much/often?

_____

_____

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Do you ingest caffeine daily? **Y** N
If so, how much and of what? _____

Do you take opiates (vicodin, hydrocodone, tramadol, codeine, fentanyl, oxycodone, heroin)? **Y** N

Do you take any stimulants (Adderall, Ritalin, Methamphetamine)? **Y** N

Do you take any sedatives like barbiturates, benzodiazepines or hypnotics (sleep medications)? **Y** N

Do you use any recreational drugs? **Y** N

What type and how much/often? _____

_____

Are you sexually active? **Y** N With men, women or both? _____

Do you practice safe sex (monogamy or using condoms)? Y **N**

Are you worried you might currently have an STI? **Y** N

Do you feel safe in your relationship? Y **N**

Does your partner ever hit you, threaten you or force you to have sex? **Y** N

Does your partner(s) use IV drugs? **Y** N

Do you have any sexual problems or concerns you'd like to discuss? **Y** N

MEN ONLY

Have you ever had problems with your prostate? **Y** N

How strong is your urine stream? Strong **Okay** **Weak** **Varies**

Do you ever dribble urine or are you ever incontinent? **Y** N

Do you ever have pain when urinating? **Y** N

Do you ever see blood in your urine? **Y** N

Do you ever have trouble getting an erection? **Y** N

Do you ever have problems with ejaculation (difficulty, pain, blood)? **Y** N

Have you ever had an elevated PSA blood test? **Y** N

WOMEN ONLY

Age at menopause (last period ever)? _____

Have you had any bleeding since menopause? **Y** N

Have you had a hysterectomy? **Y** N When? _____

Since menopause have you taken or used estrogen and/or progestin? **Y** N

Are you currently taking or using estrogen and/or progestin? **Y** N

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Last pap: _____ Results: Normal **Abnormal** **Don't know**

Have you ever had an abnormal pap? **Y** N

Please explain: _____

Have any of your relatives had ovarian cancer? **Y** N

Do you have any vaginal complaints? **Y** N

Please explain: (pain, itching, swelling, discharge, etc…):

_____

Last Mammogram: _____Results: Normal **Abnormal** **Don't know**

Have you ever had an abnormal mammogram? **Y** N

Please explain: _____

_____

Have any of your relatives had breast cancer? **Y** **N**

Do you have any breast complaints? **Y** **N**

Please explain: (pain, lumps, rashes, nipple changes, etc…): _____

_____

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