SOUTH ISLAND MEDICAL
Primary & Immediate Care

Wellness 65+ Form

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, Other

Specialty	Provider Name	Facility/Clinic Name and Location

Please list **ALL MEDICAL DEVICES** you use. (Ex. Wheelchair, walker, cane, prosthesis, CPAP, oxygen, etc)

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

ADVANCED DIRECTIVES - Please circle answers

Do you have a living will or healthcare directive? Yes **No** **Unsure**

Do you have a DPOA (durable power of attorney) for healthcare? Yes **No** **Unsure**

If yes, who is it? ____

HEALTH AND SAFETY QUESTIONS- Please circle answers

How would you describe your general health: Excellent Very Good Good **Fair** **Poor**

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

Do you eat 2 or more meals daily? Yes **No**

Do you eat fruits and vegetables every day? Yes **No**

On average, how many days per week do you do moderate exercise, like gardening or a brisk walk? ____________

On average, how many minutes do you exercise at this level each day? ______________________________

Do you have any tooth or oral problems that interfere with eating? **Yes** No

Do you wear dentures? **Yes** No

Name of dentist: ______________________________Date of Last visit:__________________________

Do you have any hearing difficulties? **Yes** No

Do you wear hearing aids? **Yes** No

Do you often ask people to repeat what they've said? Or do you act if you did hear so you don't have to ask for repeats? **Yes** No

Is urination or leaking urine causing any problems with your daily activities or sleep? **Yes** No

Do you have any difficulties with walking or balance? **Yes** No

Have you fallen 2 or more times in the past 12 months? **Yes** No

If yes, what were the circumstances? ______________________________

How many days a week does pain or fatigue keep you from doing things you like to do?______________

Do you regularly use seatbelts/helmets? Yes **No**

Do you have working smoke detectors on all floors of your home? Yes **No**

Are the stairs at home well lit and do they have handrails? Yes **No** N/A

If you have guns in the home, are they secured/locked? Yes **No** N/A

Do you need help with any of the following?

Preparing Meals **Yes** No Managing Money **Yes** No Grocery Shopping **Yes** No

Doing housework **Yes** No Taking Medicine **Yes** No Transportation **Yes** No

Making and keeping appointments **Yes** No

Do you need help with any of these:

Dressing **Yes** No Using the toilet **Yes** No Bathing **Yes** No

Eating **Yes** No Walking **Yes** No Getting in/out of chairs **Yes**

No

PERSONAL/SOCIAL HISTORY QUESTIONS

What is your gender (circle)? Female Male Transfemale Transmale Non-binary Choose not to answer

Who do you live with? ______________________________

Marital Status (circle): Single Married Divorced Widow/Widower

Do you have any children? Yes No If so, how many?______________ Do any live nearby? Yes No

Do you have any pets? Yes No Details: ______________________________

Do you have a support circle? Family, friends, work, volunteer, church, etc… Yes No

What are your hobbies? What do you do in your spare time? ______________________________

____

Have you had any major changes in your life this past year? **Yes** No

If so, please explain: ______________________________

____

How often is stress a problem for you in handling such things as your health, finances, family or social relationships or work? Never Rarely Sometimes **Often** **Always**

During the past **2 weeks**:

-Have you been bothered by feeling down, depressed or hopeless?

Not at all Several days **More than half the days** **Nearly every day**

-Have you been bothered by little interest or pleasure in doing things?

Not at all Several days **More than half the days** **Nearly every day**

-Feeling anxious nervous or on edge?

Not at all Several days **More than half the days** **Nearly every day**

-Not being able to control or stop worrying

Not at all Several days **More than half the days** **Nearly every day**

Do you drink alcohol? Yes No

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

____

Have you ever used nicotine or tobacco products (cigarettes, chew, or e-cigarette/vaping device)? Yes No

If yes, what type and how much/often? (ex. 1/2 pack per day, tin of chew weekly):____________________

____

Do you use marijuana products ? Yes No

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

____

Do you ingest caffeine daily? Yes No

If yes, how much and of what? ____

Do you use any other recreational drugs? Yes No

If yes, what type and how much/often? ____

Have you ever had sex? Yes No If no, skip to next section

Have your sexual partners included (circle): Men Women Transmen Transwomen Non-binary people

Do you use condom or other barrier during sex? Yes No

How many sexual partners have your had in the last 3 months? _______

Have you been tested for HIV? Yes No

Are any of your current sexual partners HIV positive? Yes No

Do you have any concerns about your sexual health or pleasure? Yes No

PERSONAL AND FAMILY HISTORY

Do you have a parent, brother or sister who had an abdominal aortic aneurysm? **Yes** No Don't know

Do you have a personal or family history of breast cancer? **Yes - relative**:__________ No Don't know

Do you have a personal or family history of ovarian cancer? **Yes - relative:**_________ No Don't know

Did any of the following family members develop heart disease? Circle all that apply.

Before age **55**: father, brother or son None before age 60 Don't know

Before age **60**: mother sister or daughter None before age 60 Don't know

Have you had a mother, father sister, brother, daughter or son diagnosis with the following? (circle relative)

Colon cancer No **Yes - at what age:**_______ Don't know

Colon polyps No **Yes - at what age:**_______ Don't know

Have you had a grandparent, aunt, uncle, niece or nephew diagnosis with the following? (circle relative)

Colon cancer No **Yes - at what age:**________ Don't know

WOMEN ONLY

Age at menopause (last period ever)? ______________________________

Have you had any bleeding since menopause? **Yes** No

Are you taking a daily supplement that has both vitamin D and calcium? Yes **No**

Do you have any breast complaints? **Yes** No

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