ANNUAL WELLNESS VISIT QUESTIONNAIRE – Please complete the front and back

Please complete this checklist before seeing your doctor or nurse.

Patient Name: ______________________________ DOB: ______________ Today's Date: ________________

ASSESSMENTS

Do you have any of the following: (mark all that apply)

☐ Living Will ☐ Health Care Proxy ☐ Power of Attorney ☐ Do Not Resuscitate (DNR)

Do you need help with any of the following? (mark all that apply)

☐ Grooming ☐ Dressing ☐ Toilet Use ☐ Housework ☐ Preparing Meals

☐ Eating ☐ Walking ☐ Bathing ☐ Taking medications ☐ Driving

☐ Household Finances ☐ **No assistance required with any of the items**

Do you currently work? ☐ No ☐ Yes

Do you exercise/what is your physical activity level? ☐ Very light ☐ Light ☐ Moderate ☐ Heavy ☐ Very Heavy

Are you currently in Pain? ☐ No ☐ Yes - Location:______________________

In the past 12 months, have you fallen 2 or more times? ☐ No ☐ Yes ☐ Yes, with injury (educational information provided)

Do you currently use a walker, cane or other device ☐ No ☐ Yes

DEPRESSION SCREENING PHQ - 9

During the last 4 weeks, how often have you been bothered by any of the following problems?	Not at all (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or asleep too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure, or have let yourself or family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. 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	☐	☐	☐	☐
9. Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

PREVENTATIVE MAINTENANCE

Prev Maintenance	Last Done (provide date)	Where Done (ie.PCP name, Walgreens)	If not performed, why?
Flu Vaccine			☐ Allergy ☐ Refused
Pneumonia Vaccine			☐ Allergy ☐ Refused
Colonoscopy			☐ FOBT done ☐ Cologuard done ☐ Sigmoidoscopy done ☐ Refused ☐ Colectomy ☐ Colorectal Cancer
Mammogram			☐ Breast cancer ☐ Mastectomy ☐ Refused
Bone Density			☐ Refused
PSA			☐ Refused

see other side for more questions

In an effort to coordinate your care, please provide a comprehensive list of all providers that you see. Please note if they are out of state physicians. Specialist providers include Cardiologists, Gastroenterologist, Endocrinologist, Opthamalogists, Optometrists

Provider Name:		Specialty:
1.		
2.		
3.		
4.		
5.		

Alcohol Screening (please circle your answers)

1. How often do you have a drink containing alcohol?
   (1) Never ***(Skip to question 9 & 10)***
   (2) Monthly or Less
   (3) 2 to 4 times a month
   (4) 2 to 3 times a week
   (5) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7,8 or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

Skip to questions 9 and 10 if total score for questions 2 & 3=0

4. How often during the last year have you found that you were not able to stop drinking once you started?
   (1) Never
   (2) Less than monthly
   (3) Monthly
   (4) Weekly
   (5) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (1) Never
   (2) Less than monthly
   (3) Monthly
   (4) Weekly
   (5) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (1) Never
   (2) Less than monthly
   (3) Monthly
   (4) Weekly
   (5) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (1) Never
   (2) Less than monthly
   (3) Monthly
   (4) Weekly
   (5) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   (1) Never
   (2) Less than monthly
   (3) Monthly
   (4) Weekly
   (5) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   (0) No
   (2) Yes but not in the last year
   (4) Yes during this year

10. Has a relative, friend, doctor or another healthcare worker been concerned about your drinking or suggested you cut down?
    (1) No
    (2) Yes but not in the last year
    (4) Yes during this year

Zone I – 0-7 Zone II – 8-15 Zone III – 16-19 Zone IV - 20-40

Did you know?

The information we are asking is based on CMS guidelines. This information is important for our providers to be able to better assist you. Any time you see other specialists providers, please provide them with your Jupiter Medical Groups PCP name and fax number of 561-746-3770 so they can send us progress reports from your visits with them.