Magnolia Family Medicine Phone: 910-796-3212 Fax: 910-796-3216

ANNUAL WELLNESS/HEALTH ASSESSMENT VISITS Today's Date:

Your Full Name: _____ Date of Birth _____

Street Address: _____
Street City Zip Code

Phone Numbers: _____ Email: _____

Please check the box that answers the questions below and write any additional information that will help us meet your needs better. ***Please, No Blank Answers***.

1. What is your natural language? □ English □ Spanish Other: _____

2. Where do you currently live?
   - □ Independent house, apartment, mobile home
   - □ Assisted Living Apartment, or board & care Name: _____
   - □ Nursing home Name: _____
   - □ Other: _____

3. What is your current living arrangement? (check each that applies)
   - □ Live Alone
   - □ With spouse/significant other
   - □ With child(ren)
   - □ With other relative(s)
   - □ With non-relative(s)
   - □ With paid caregiver

4. A. Do you plan on changing your present living arrangements in the next 6 months?
   □ Yes □ No Describe_____
   B. Do you feel safe in your neighborhood? □ Yes □ No _____

5. Have you seen your current (Primary Care Physician) PCP in the last 3 months? □ No
   □ Yes Who is it? _____

6. Are you under the care of a Specialist, if yes Name & Specialty? □ No
   □ Yes Names/Specialties_____

7. Have you been to the Emergency Room in the past 6 months? □ No
   □ Yes, number of times: _____ Why?_____

8. Have you been in a Skilled Nursing Facility in the past 12 months? □ No
   □ Yes, number of times: _____ Why?_____

9. Have you stayed overnight in a hospital in the past 12 months? □ No
   □ Yes, number of times: _____ Why?:_____

10. In general would you say your health is: (Check one answer)
    □ Excellent □ Very Good □ Good □ Fair □ Poor

11. Do you feel you have a problem with:
    → Alcohol Abuse □ Yes □ No *OR* → Drug Abuse □ Yes □ No
    How often do you drink alcohol? _____
    EXAMPLE 1-2 drinks, 3x a wk

12. Do you smoke or use tobacco products? □ Yes □ No Type _____
12a. If YES, are you interested in a Smoking Cessation Program? □ Yes □ No

13. A. Are you a former smoker? □ Yes □ No Year Started _____ Year Quit_____
B. Using ECig? □ Yes □ No Chew? □ Yes □ No

14. Have you had sex in the past 12 months? □ Yes □ No
14a. Please circle: vaginal, oral, or anal
14b. With: □ Men only □ Women Only □ Both Men and Women
14c. Use Protection? □ Yes □ No Type _____
14d. How many sexual partners have you had in your lifetime?_____

15. Have you ever had a Sexually Transmitted Disease?
□ Yes □ No **If NO, go to question 16**
Chlamydia □ Yes □ No GC □ Yes □ No OTHER _____
Syphillis □ Yes □ No Herpes □ Yes □ No

16. Have you ever been sexually abused? □ Yes □ No

17. Have you ever been treated for the following conditions? If yes, describe:
□ Yes □ No Stroke _____
□ Yes □ No Heart Attack _____
□ Yes □ No Chest Pain _____

18. Do you have any wounds, sores or skin breakdown? □ No
□ Yes Describe_____

19. For each of the activities, indicate whether: you are able to do this **without help** or **needs some help performing activity**:

	NEEDS SOME HELP	ABLE TO DO WITHOUT HELP
Using the toilet ……	□	□
Bathing ……	□	□
Dressing …….	□	□
Eating ……..	□	□
Getting in/out of bed or chairs	□	□
Walking ……	□	□
Managing Money ……..	□	□
Taking Medications …….	□	□
Preparing Meals ……	□	□
Shopping and Errands ……	□	□
Housekeeping Chores ……..	□	□
Using the Telephone…….	□	□

20. If you receive help with any of the activities selected in above question, **who is the helper**? (or circle Not Applicable)

_____ □ Yes □ No
Name Relationship Phone Number **May we contact?**

21. Do you use any of the following special equipment **because of a disability or health problem? Circle all that apply**:
1. None 2. Grab Bars 3. Bedside Commode 4.Wheelchair 5. Ramps
6. Walker 7. Hospital Bed 8. Cane 9. Raised Toilet Seat 10. Hoyer Lift

22. CIRCLE if you currently use or receive any of the following?
Feeding Tube Colostomy Care Oxygen Catheter Care Other_____

23. Are you CURRENTLY being treated for any of the following health conditions?
For any "YES" answer, please describe:

□ Yes □ No Dialysis _____
□ Yes □ No Memory Loss_____
□ Yes □ No Arthritis _____
□ Yes □ No Urinary Problems _____
□ Yes □ No Breathing Problems _____
□ Yes □ No High Blood Pressure _____
□ Yes □ No Cancer _____
□ Yes □ No Circulation Problems _____
□ Yes □ No Osteoporosis _____
□ Yes □ No Stomach/Bowel Problems _____
□ Yes □ No Recent Fracture (last 12 months) _____
□ Yes □ No Parkinson's _____
□ Yes □ No Ankle/Leg Swelling _____
□ Yes □ No Uncorrected Hearing Loss _____
□ Yes □ No Congestive Heart Failure
□ Yes □ No If you have Congestive Heart Failure, have you been hospitalized for it in the last 12 months?

Other (Describe)_____
_____

24. Do you need help at home because of health problems □ Yes □ No
24a. Are you unable to get help? □ Yes □ No □ Not Applicable

25. Have you fallen in the last 12 months? □ Yes □ No
25a. If yes, how many times? _____
25b. If yes, did you go to the hospital?_____

26. Are you currently receiving any of the following services from an agency?

□ Yes □ No Home Health Nurse
□ Yes □ No Home Health Aide
□ Yes □ No Social Worker
□ Yes □ No Adult Day Care Center
□ Yes □ No Physical, Occupational, Speech Therapy at Home
□ Yes □ No Transportation Assistance

27. Do you currently have any pain? □ Yes □ No If NO, go to question #28

27a. Pain Severity Scale 1-10 (1 is less severe, 10 is most severe)

□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

27b. Do you take medicine for pain? □ Yes □ No

If YES, name of medicine _____

27c. Does the pain medicine provide adequate relief of your pain?

□ All the Time □ Most of the Time □ Some of the Time □ Never

If YES, describe pain _____

28. Which of the following statements applies to your health? Check all that apply.

□ Must stay in bed all or most of the time because of physical limitations
□ Must stay in the house all or most of the time because of physical limitations
□ Need help from another person in getting around inside or outside the house
□ Do not need help or special aid, but have trouble getting around freely
□ Not limited in any way

29. Do you have Diabetes? □ Yes □ No

29a. If Yes, have you had a Diabetic Eye Exam done in the past year?

□ Yes □ No/Don't know Place_____

29b. Have you had a Glaucoma (Eye Pressure) Screen done in the past year?

□ Yes □ No/Don't Know Place _____

30. How is your eyesight? (While wearing glasses or contacts, if applicable)

□ Excellent □ Good □ Fair □ Poor □ Blind

31. Do you get a flu shot every year? □ Yes □ No □ Don't Know Where?_____

32. Have you ever had a pneumonia shot? □ Yes □ No □ Don't Know When? _____

33. Have you ever had a Zostavax shot (shingles vaccine)? □ Yes □ No □ Don't Know

34. Do you feel depressed? □ Yes □ No

34a. If YES, are you currently being treated for depression? □ Yes □ No

34b. Do you want to discuss treatment options on your next appointment? Yes No

35. Have you completed an **Advance Directive**? □ Yes □ No

(A document that directs your health care wishes in the event you become ill)

35a. If YES, is it on file with your PCP? □ Yes □ No

35b. If NO, are you interested in receiving information? □ Yes □ No

35c. Who is responsible to carry out your wishes? _____

35d. Circle Answer/s: Comfort Measures, DNR, Organ Donor, Resuscitate or NA