ADULT WELLNESS QUESTIONNAIRE Page 1

Patient Name:_____ DOB:_____ Date:_____
New issues to discuss with us today:_____
_____

Current Medications
(include over-the-counter and supplements)

Current Medical Conditions/Specialists you see

Medications	Medications	Medical Condition	Medical Condition	Specialists

Medical Allergies/Intolerances and your reaction to them

list here:		

Do you use tobacco products? Yes No Former If yes, How much/many per day? _____How many years? ____
Are you ready to quit tobacco products? Yes No Maybe
Do you use Alcohol or other Drugs? No Yes, if so,
what?_____

SAFETY

Have you fallen recently? No Yes If yes, how many times in the last month?_____

If yes, did you seek medical attention? No Yes If yes, Where?_____

Do you have difficulty maintaining your Activities of Daily Living (Shopping, Dressing, Grooming, Eating, maintaining your home)? NO Yes If yes, what are your concerns?_____
_____

Do you have any other safety concerns? No Yes If yes, what are they?:_____
_____

Do you have a living Will? Yes No Do you have a Durable Power of Attorney for Healthcare? Yes No

Does your family know your wishes? Yes No

Provider reviewed/Signature:_____

Patient Name:_____ DOB:_____ Date:_____

Mood Indicator-PHQ-9 Page 2

	Over the last 2 weeks, How often have you been bothered by any of the following problems?	Not at all	Several Days	More than 1/2 of the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself-or that you are a failure or have let yourself of your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
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	0	1	2	3
9	Thoughts that you would be better off dead, or of hurting yourself in someway	0	1	2	3
	Total each column	0			
	Grand Total				
10	If you have any of the above problems, how difficult is it for you to do your work, take care of things at home, or get along with other people? circle one	Not difficult at all	Somewhat difficult	Very Difficult	Extremely Difficult

Provider Notes:_____

_____

Provider reviewed/Signature:_____

Patient Name:_____ DOB:_____ Date:_____

PREVENTATIVE SCREENING/VACCINATION SCHEDULE HANDOUT
Page 3

Exam	Date(s) Done	How often?	Recommended Follow-up	Notes
EKG @ IPPE for screening		Only if needed		
Chest X-Ray Not routine		Only if needed		
Ultrasound for Abdominal Aortic Aneurysm		Once in a lifetime for screening		
Diabetic A1C Screening A1C		2-4 times yearly yearly		
Diabetic Urine Microalbumin (Protein)		yearly		
Diabetic Foot Exam		yearly		
Eye Exam With dilation if Diabetic		yearly		
Cholesterol Monitoring Screening		1-2 times yearly Every 5 years		
Prostate Screen labs		yearly		
Pap Smear		Annually if high risk, every 2 years otherwise		
Mammogram		40+ = yearly		
Bone Density Screening		If at risk, every 2 years		
Colonoscopy		Every 10 years for low risk		
Stool for Occult Blood (home cards)		yearly		
Immunizations	**Date(s) Done**	**Recommended Follow-up**		**Notes**
Pneumonia Vaccine		15 years		
Influenza Vaccine		annually		
Shingles Vaccine		Once in a lifetime	-----	-------
Tetanus Vaccine		Every 5-10 years		

Please understand that recommendations do not in any way guarantee coverage by your carrier.

Patient Signature:_____Date:_____

Provider Signature:_____Date:_____