Annual Wellness Patient History Form

Name: DOB: DATE:

Review of Medical and Surgical History

List all physicians that you see on a regular basis

Name of physician	Reason for visits to this physician

Please list any Hospital Admissions/Previous Surgery: (as best as you can remember)

Year	Hospital	Reason

Please list all medications you are taking, including calcium and vitamins:

Name	Dose	Frequency	Name	Dose	Frequency

Do you have any allergies to Medications? ☐ Yes ☐ No

If yes, please list the medication and your reaction: _____

_____

_____

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My Health History

Do you now have or have you ever had any of the following? Check any that apply.

__Anemia
__Diabetes
__High Blood Pressure
__High Cholesterol or Triglycerides
__Any disease of the stomach, intestines or bowel
__Any disease of the liver
__Any disease of the kidneys
__Osteoporosis
__Gout
__Arthritis If so what type and location?
__Heart disease.

If yes have you had:

__Coronary artery disease
__Coronary bypass surgery
__Coronary angioplasty
__Congestive heart failure
__Disorders of heart rhythm
__Heart valve problems
__Pacemaker
__Implanted defibrillator
__Aneurysm of any blood vessel
__Phlebitis or blood clots requiring blood thinners
__Chronic Obstructive Lung Disease (COPD, emphysema)
__Tuberculosis or a positive TB skin test
__Asthma
__Stroke
__Migraine headaches
__Other frequent headaches
__Seizures or epilepsy
__Cancer of the skin
__Cancer other than skin
__Depression
__Anxiety disorder
__Panic attacks
__Alcoholism
__Substance abuse or misuse
__Eating disorder (Anorexia or Bulemia)
__Other psychiatric disorder
__Thyroid disorders
__Any other condition requiring ongoing medical treatment: _____

Social History

Do you or have you ever smoked or chewed tobacco? ☐ Yes/☐ No. If "Yes":

How much? _____ How long? _____ Have you quit? _____ When? _____

Do you drink alcohol? ☐Yes/☐ No. If "Yes", how much/how often? _____

Do you or have you ever used illicit drugs? ☐ Yes/☐ No. If "Yes", please list type of illicit drugs used and date last used:

_____

Do you feel you eat a balanced diet? ☐ Yes/☐ No. Please list types of foods included in your daily diet:

_____

_____

Please list any social activities in which you are involved:

_____

_____

Do you exercise? ☐ Yes/☐ No. If "Yes", please list the type of physical activity:

_____

Name: DOB: DATE:

Family Health History

☐ I am adopted and unaware of parental medical history

	Alive ?		Complete one of the following:		
Your Family	Yes List age	No- List age at time of death	If alive, Current Health	If deceased, Cause of Death	
Mother					
Father					
Brothers					
Sisters					
Children					

In answering the following questions consider parents, brothers, sisters, children, grandparents, aunts, uncles and cousins. If any answer is affirmative list the type of relations. For example if any family members have diabetes you might list "mother, father, 1 brother".

Does any member of your family have the following? (use this as a guide to what we are looking for above)

__Heart disease
__Diabetes
__Stroke
__High blood pressure
__Asthma
__Kidney disease
__Prostate cancer
__Colon or rectal cancer
__Colon polyps
__Breast cancer
__Endometrial (uterus) cancer
__Melanoma
__Thyroid cancer
__Other cancer
__Sudden death in someone who appeared to be well
__Severe visual loss before the age of 55
__Severe hearing loss before the age of 60
__Dementia
__Birth defects
__Seizures
__Mental illness
__Alcoholism

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Hearing Impairment

Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?

☐ Yes/☐ No/☐ Sometimes

Do you feel that people are mumbling or not speaking clearly?

☐ Yes/☐ No/ ☐ Sometimes

Do you find yourself asking people to speak up or repeat themselves?

☐ Yes/☐ No/☐ Sometimes

Do you have difficulty understanding speech on the telephone?

☐ Yes/☐ No/☐ Sometimes

Do you find it difficult to understand a speaker at a public meeting or a religious service?

☐ Yes/☐ No/☐ Sometimes

Do you experience ringing or noises in your ears? ☐ Yes/☐ No/☐ Sometimes

Do you hear better with one ear than the other? ☐ Yes/☐ No

Have you had any significant noise exposure during work, recreation or military service?

☐ Yes/☐ No

Do you feel handicapped by a hearing problem? ☐ Yes/☐ No

Activities of Daily Living

Please review the following self-care activities and mark whether or not you are able to do these things without assistance:

Eating ☐ Yes/☐ No

Dressing ☐ Yes/☐ No

Bathing☐ Yes/☐ No

Getting out of bed/chair ☐ Yes/☐ No

Using the toilet ☐ Yes/☐ No

Controlling bladder and bowel ☐ Yes/☐ No

Preparing meals ☐ Yes/☐ No

Performing housework ☐ Yes/☐ No

Taking prescription medication ☐ Yes/☐ No

Going on errands ☐ Yes/☐ No

Managing finances ☐ Yes/☐ No

Using a telephone ☐ Yes/☐ No

If you are unable to perform any of the self-care activities, please briefly describe what difficulties you experience:

_____

_____

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Falls Risk

Have you fallen in the past year? ☐ Yes/☐ No

If "Yes", how many times have you fallen? _____

Describe what caused you to fall, or what you were doing when you fell:

_____

_____

Have you experienced difficulty with any of the following items:

Lower extremity weakness ☐ Yes/☐ No Walking ☐ Yes/☐ No

Unstable Balance ☐ Yes/☐ No Dizziness ☐ Yes/☐ No

Home Safety

Please review the following list of items and circle the ones you currently have in your home:

Swimming Pool	Scatter Rugs	Barred windows/doors
Steps with handrails	Alcohol	Weapons
Steps without handrails	Clutter	Night Light
Railings	List of emergency phone numbers	Locks
Smoke Alarm	Accessibility to summon help	
Electric blanket/mattress pad	Electric space heater	

Individual's Potential Risk Factors for Depression

Have you ever experienced problems with or been treated for depression, or other mood disorders? ☐ Yes/☐ No

If "Yes", please describe:

_____

_____

In the past month have you felt down, depressed or hopeless and had trouble shaking the feeling? ☐ Yes/☐ No

Have you taken little pleasure in the things you enjoy the most? ☐ Yes/☐ No

If you answered <u>yes</u> to either of these questions please continue by checking the appropriate boxes:

	Not at all	Several days	More than half the days	Nearly every day
I have had little interest in doing things				
I have felt down, depressed or hopeless				
I have had trouble falling or staying asleep or sleeping too much				
I have felt tired and had little energy				
I have had poor appetite or have been overeating				
I have felt bad about myself or felt that I let myself or my family down				
I have had trouble concentrating on TV or reading				
I have been moving slowly or have been fidgety or restless				
I have thought that I might be better off dead				

These symptoms have made it difficult for me at work, or getting along with people or taking care of things at home: ____ Not at all; ___Somewhat; ___very much; ___extremely so.