Annual Wellness Physical for those 65 and older

Name:_____________________________ Date of Birth:__________________ Today's Date:____________________

List any Doctor you see regularly: Reason: Month/year of last appointment

____ _________________________ _____________________________

____ _________________________ _____________________________

____ _________________________ _____________________________

____ _________________________ _____________________________

________________Date of your last eye exam? Name of clinic/provider:____

________________Date of your last dental exam? Name of clinic/provider:____

List any immunizations you have at another clinic/ER/pharmacy: Date:

____ ________________

____ _________________

Have you ever had colon cancer screening (colonoscopy)? Yes No

Date:_____________________ Physician or clinic:____

Are you interested in continuing colon cancer screening? Yes No

Have you ever been tested for hepatitis liver infection or HIV? Yes No

Date:______________________ Physician or clinic: ____

Are you a current (or former) smoker? Yes No

How many years have you smoked? ________ Average number of packs you smoked per day? __________

When did you quit?__________________

Can you shop for groceries or clothes without help? Yes No

Question		
Can you prepare your own meals?	Yes	No
Can you do your own housework without help?	Yes	No
Can you handle your own money without help?	Yes	No
Can you bathe, dress, and get around your home without help?	Yes	No
Do you usually fasten your seat belt while in the car?	Yes	No
Can you get places out of walking distance without help? (drive, bus, etc..)	Yes	No
If you drive, are you having difficulties driving your car?	Yes	No
Are you afraid of falling?	Yes	No
Have you fallen within the past 3 months?	Yes	No
Have you fallen two times in the past year?	Yes	No
Do you have to use a cane, walker, or crutches when you walk?	Yes	No
Do you need to hold on to furniture when you walk to prevent falling?	Yes	No
Do you understand your own physical limitations?	Yes	No
Do you fall, or feel dizzy, when standing up?	Yes	No
Do you have trouble taking your medications the way you have been told to take them?	Yes	No
Do you have a living will or advance directive?	Yes	No
Do you worry about your memory?	Yes	No

Over the last 2 weeks how often have you been bothered by the following problems? (circle your answer)

0=Not at all 1=Several Days 2=More than half the days 3=Nearly every day

0 1 2 3 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/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 someone 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 have noticed. Or the opposite-

Being fidgety or restless a lot more than usual.

0 1 2 3 9. Thoughts that you would be better off dead, or of hurting yourself in some way.

If you circled ANY problems, how DIFFICULT have these problems made it for you to do your work,

take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	very difficult	extremely difficult
☐	☐	☐	☐

MEN'S HEALTH

You may skip the section below if you completed this form previously and it is unchanged.

Do you have a family history of prostate cancer? Yes No

If yes, what is the relation to you?____________________________ How old were they?______________

Do you wish to discuss any sexual problems? Yes No

WOMEN'S HEALTH

You may skip the section below if you see an OB/GYN for annual wellness exam,

or if you have completed this form previously and it is unchanged.

________________ Date of your last mammogram

Do you have a family history of breast cancer? Yes No

Relation to you:_________________________ Age at their diagnosis:____________________

Are you interested in continuing breast cancer screening? Yes No

________________Date of your last pap smear

Any previously abnormal pap smear? Yes No

Have you had a hysterectomy? Yes No

Are you interested in continuing cervical cancer screening? Yes No

_________________ Date of your last DEXA (Bone Density Scan)

Have you ever been told you have osteopenia or osteoporosis? Yes No

Do you wish to discuss any sexual problems today? Yes No

Do you have problems with your gait or ability to transfer out of bed or out of a chair?

☐ No

☐ Weak

☐ Significant impairment

During the past 4 weeks how much bodily pain have you generally had?

☐ No pain

☐ Very mild pain

☐ Mild pain

☐ Moderate pain

☐ Severe pain

During the past 4 weeks was someone available to help you if you needed and wanted help? *(If you felt anxious, lonely, needed help with chores, or were ill, was someone able to help you.)*

☐ Yes, as much as I wanted

☐ Yes, quite a bit

☐ Yes, some

☐ Yes, a little

☐ No, not at all

During the past 4 weeks what was the hardest physical activity you could do for at least 2 minutes?

☐ Very heavy

☐ Heavy

☐ Moderate

☐ Light

☐ Very light

Are you having difficulty driving your car?

☐ Yes, often

☐ Sometimes

☐ No

☐ Not applicable, I don't drive

During the past 4 weeks how many drinks of wine, beer, or other alcoholic beverages did you have?

☐ 10 or more per week

☐ 6-9 per week

☐ 2-5 per week

☐ 1 drink or less per week

☐ No alcohol at all

Do you exercise for about 30 minutes 5 or more days a week?

☐ Yes, most of the time

☐ I exercise, but usually not this much

☐ No, I usually don't exercise

How confident are you that you can control and manage most of your health problems?

☐ Very confident

☐ Somewhat confident

☐ Not very confident

☐ I do not have any health problems

During the past 4 weeks how would you rate your health in general?

☐ Excellent

☐ Very good

☐ Good

☐ Fair

☐ Poor