PMC
Professional Medical Corporation

Date:_______________

# Annual Wellness Questionnaire

Patient Name: ____________________________ Date of Birth: _________________ Age:__________

1. How would you rate your overall health?
   Excellent  Very Good  Good  Fair  Poor  Very Poor
2. Do you have any concerns about your health?  YES  NO
   If yes, please list your concerns: ________________________________________
3. How would you characterize your overall physical functioning?
   Excellent  Very Good  Good  Fair  Poor  Very Poor
4. Are you physically active?  YES  NO
   If yes: Type of activity? ___________________________________
   How many times per week? ________________________
   How many minutes at one time? ____________________
5. Do you characterize yourself as frail?  YES  NO
   If Yes - Slightly frail  Moderately frail  Very frail  Extremely frail
6. Are you currently using any durable medical equipment?  YES  NO
   Please circle: Walker, Wheelchair, Cane, Crutches, Hearing Aids, Glucometer, CPAP, Oxygen
   Other:_____________________________
7. What is your pain level? 1 2 3 4 5 6 7 8 9 10
8. Have you had a vision screen in the last year?  YES  NO
   Date:____________
9. Do you have any concerns regarding your hearing?  YES  NO
   Please list concerns if yes: __________________________________
10. How would you rate your oral health?
    Excellent  Very Good  Good  Fair  Poor  Very Poor
11. Have you been to the dentist in the last year?  YES  NO
    Date:____________
12. How would you rate your diet? **Please choose one:**
    As Advised By Doctor  Very Healthy  Healthy  Moderately Healthy
    Moderately Poor  Poor  Very Poor
13. Do you feel overly tired or fatigued?  YES  NO
14. Do you feel lonely or isolated?  YES  NO
15. Please list the people currently residing with you and their relationship to you:
    ________________________________________________________________
16. How is your stress level?
    High  Moderately high  Moderately low  Low  Very low
17. Do you have trouble controlling your anger?  YES  NO
18. Do you currently have a durable power of attorney?  YES  NO
    a. Is it on file with the practice?  YES  NO

19. Are you sexually active? YES NO
    a. Sexual partners – Men Women Both
    b. Multiple partners? YES NO
20. Do you have a history of Sexually Transmitted Infections (STI)? YES NO
21. Do you use or have a history of using IV drugs? YES NO
22. Do you wear a seat belt when you drive or ride in the care? YES NO
23. Please answer the following questions regarding your home safety:
    1. I have steps to enter my home or stairs inside my home YES NO
    2. There are handrails on the stairs YES NO
    3. I have loose throw rugs in my house YES NO
    4. I have clutter on the floors YES NO
    5. I have poor household lighting YES NO
    6. I have grab bars in the bathroom YES NO
    7. Do you use any medical equipment while walking YES NO
    8. Have you fallen in the past year? YES NO
24. Please answer the following questions regarding your abilities:
    1. Can you prepare meals without assistance YES NO
    2. Can you dress yourself without assistance YES NO
    3. Can you use the toilet without assistance YES NO
    4. Can you perform basic hygiene without assistance YES NO
    5. Can you bathe and/or shower yourself without assistance YES NO
    6. Do you ever lose your balance or fall when walking? YES NO
    7. Can you use the phone without assistance YES NO
    8. Can you manage your medication without assistance YES NO
    9. Can you access your mode of transportation without assistance YES NO
    10. Can you do your own housework YES NO
    11. Can you manage your finances without assistance YES NO
    12. Can you shop without assistance YES NO
    13. Can you do laundry without assistance YES NO
25. Have you had any hospital stays in the past 12 months? YES NO

    If yes, please provide: Date of service: ____________________

    Name of hospital: ___________________

    Reason for hospitalization: ___________
26. Do you have any of the following surgical history?

    Hip Replacement Back/Spinal Surgery Gastric Bypass Knee Replacement

    Breast Surgery Heart Bypass (CABG) C-Section Prostate Surgery
27. Do you have a family history of an abdominal aortic aneurysm? YES NO
28. Do you have a family history of (please circle all that apply):

    Cancer Kidney Disease Lung Disease Hypertension Liver Disease Dementia

    Stroke Bipolar Disorder Schizophrenia Heart Disease High Cholesterol Diabetes

29. Do you have any known medication allergies/reactions: YES NO

_______________________________ _______________________________

_______________________________ _______________________________

30. Are you currently using any prescribed opioids (pain medications)? YES NO
Examples: Fentanyl, Hydrocodone, Morphine, Codeine

31. Have you ever intentionally taken more medication than prescribed or medication that was not prescribed for you? YES NO

| MEDICATIONS AND SUPPLEMENTS | | |
|---|---|---|
| **List all medications, vitamins, minerals (like calcium), and supplements (include over-the-counter)**<br>***Provide a written list of your medications if available*** | | |
| **Medication Name** | **Dosage and Directions** | **Reason for Medication** |
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32. **Please list all other doctors and their phone numbers, which you currently see:**

**(Include eye doctors, dentist, podiatrist, medical equipment supplier, etc.)**

**Name/Phone**: **Name/Phone**:

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

| OFFICIAL USE ONLY | |
|---|---|
| **Reviewed By**<br>Clinician Name: | |
| Clinician Signature: | Date: |