Family Care of Fairview Yearly Wellness Exam Questionnaire:

Name _____ Date of Birth _____

Changes within past year

Family History:			
Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Social History:
Please check appropriate answers below and provide explanations where appropriate
Marital status: € Single € Married € Divorced € Widowed € Life Partner
Occupation: Occupational concerns: € Stress € Hazardous substances € Heavy lifting
How stressful would you rate your current living situation: (Circle number) No stress 0 1 2 3 4 5 6 7 8 9 10 Very Stressful

Health Behaviors:	
Tobacco use: € Never € Quit (when)_____ € Current smoker	
If current smoker how many packs per day for how many years_____	
Illicit drug use (including marijuana, cocaine, steroids): € Never € Past € Current	
If past or current drug use describe:	
Exposure to secondhand smoke € Yes € No	Wear a seatbelt € Yes € No
Eat a diet high in fruits and vegetables € Yes € No	Get 30 minutes of exercise 5 times a week € Yes € No

Mood Screening:	
A person's mood can have a strong influence on their health status and overall wellbeing. Over the past 2 weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things	Feeling down, depressed, or hopeless

€ Not at all	€ Not at all
€ Several days	€ Several days
€ More than half the days	€ More than half the days
€ Nearly every day	€ Nearly every day

Health Maintenance:				
Please check whether you have had the following preventive services and enter the year of the service				
Immunizations	Date		Tests	Date
Tetanus vaccine / Tdap			Pap smear/pelvic	
Pneumonia vaccine			Mammogram	
Prevnar 13 vaccine			Bone Density Exam	
Influenza vaccine			Colonoscopy	
Shingles vaccine			Prostate test	

Alcohol Use Assessment:	
1. How often do you have a drink containing alcohol?	2. How many drinks containing alcohol do you have on a typical day?
€ Never	€ 1 or 2
€ Monthly or less	€ 3 or 4
€ 2-4 times a month	€ 5 or 6
€ 2-3 times a week	€ 7 to 9
€ 4 or more times a week	€ 10 or more
3. How often do you have six or more drinks on one occasion?	
€ Never	
€ Less than monthly	
€ Monthly	
€ Weekly	
€ Daily or almost daily	

Urinary Incontinence Assessment:
Do you experience leaking in the following situations?

	Not at all	A little	Sometimes	A lot
During daily activities (work, household task)				
During physical activities (walking, swimming, or other exercise)				
During recreational activities (movies, hobbies)				
During social activities (going out with friends, family visits)				
During car trips				
In the Past few Weeks:				
Have you frequently experienced the need to urinate?				
Have you experienced leaking before an urgent need to urinate?				
Have you experienced leaking on effort, such as when sneezing, coughing, jumping, laughing, or during physical activity?				
Have you experienced a pressing or immediate urge to urinate?				
Have you noticed a change in your urination frequency?				
Do you need to urinate more than 8 times every 24 hours?				
Do you have to get up more than twice during the night to urinate?				
Do you sometimes have to strain to urinate?				

Fall Risk Screening:					
In the last 12 months have you fallen?	Yes	No	Unsure		
If yes, how many times?	1	2	3	4	5+

Were you injured as a result of this fall?	☐ Yes ☐ No ☐ Unsure

Advance Care Planning:			
Do currently have, or would you like information on, any of the following items			
Living Will: Want Information	€ Have	€ Don't Have	€
Durable Power of Attorney: Information	€ Have	€ Don't Have	€ Want
DNR Order: Want Information	€ Have	€ Don't Have	€