Marina Village Medicine

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ANNUAL WELLNESS VISIT
LIFESTYLE REVIEW

Patient Name: ____ Date: __________________

Form Completed by: ☐ Self ☐ Other: ____

NUTRITION AND PHYSICAL

1. Do you eat a varied, balanced diet? ☐ Yes ☐ No	2. If you answered NO to #1, what would you say is the main issue? ☐ Poor food choices ☐ Eating too much ☐ Not eating enough
3. In the past 7 days, how many days did you exercise? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 On the days you exercised, for how long did you exercise? ☐ 10-20 min ☐ 20-40 min ☐ 40-60 min ☐ >1 Hr	4. How intense was your typical exercise? ☐ Light (stretching or slow walking) ☐ Moderate (brisk walking) ☐ Heavy (jogging or swimming) ☐ Very Heavy (fast running/stair climbing)
5. Have you fallen 2 or more times in **the past year**? ☐ Yes ☐ No	6. Are you afraid of falling? ☐ Yes ☐ No

SAFETY AND PAIN STATUS

1. Please answer Yes or No to the following questions:
Over the last two weeks, have you…

YES	NO	
☐	☐	…experienced loss of interest or pleasure in doing things?
☐	☐	…been bothered by feeling down, depressed or hopeless?
☐	☐	…had thoughts of hurting yourself?
☐	☐	…had social problems that you feel interfere with your mental or physical health?

2. I have actual threats of physical or emotional abuse. ☐ Yes ☐ No	3. I feel safe a home. ☐ Yes ☐ No
4. In the **past 7 days**, have you been in pain? ☐ None ☐ Some ☐ A lot	5. If you are experiencing pain, please rate your pain level (1 being very little, 10 being a lot). ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

SUBSTANCE ABUSE

1. Do you use tobacco products?
   - ☐ No
   - ☐ Not currently, former tobacco user
   - ☐ Yes, current tobacco user

2. In an average week, how many alcoholic drinks to you consume?
   ☐0 ☐1-3 ☐4-7 ☐8-9 ☐10-13 ☐14 or more

3. On days when you drank alcohol, how often did you have 3 or more drinks on one occasion?
   ☐Never ☐Once during the week ☐2-3 times during the week ☐>3 times during the week

4. Please answer Yes or No to the following questions:
   If you use alcohol or other recreational drugs, have you…

YES	NO	
☐	☐	…tried to cut down or change your use?
☐	☐	…been angered or annoyed by people confronting your use?
☐	☐	…felt guilty about your use or consequences of your use?
☐	☐	…have you ever used first thing in the morning as an eye opener?

GENERAL HEALTH & WELLNESS

1. During the **past 4 weeks**, how would you rate your general health?
   ☐Excellent ☐Very good ☐Good
   ☐Poor ☐Fair

2. How confident are you that you can control & manage most of your health problems?
   ☐ Very confident ☐ Somewhat confident
   ☐ Not very confident ☐ I don't have any health problems

3. Because of any health problems, do you need the help of another person with your personal care needs such as:

YES	NO	
☐	☐	Eating
☐	☐	Bathing
☐	☐	Dressing
☐	☐	Getting around the house

4. How often do you have trouble taking medicines the way you have been told to take them?
   - ☐ I do not have to take medicine
   - ☐ I always take them as prescribed
   - ☐ Sometimes I take them as prescribed
   - ☐ I seldom take them as prescribed

5. During the **past 4 weeks**, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or deeded help just taking care of yourself.
   - ☐ Yes, as much as I wanted
   - ☐ No, not at all
   - ☐ Yes, quite a bit
   - ☐ Yes, some
   - ☐ Yes, a little

6. Do people complain that you turn up the TV volume too high?
   ☐Yes ☐ No

7. Do you find yourself asking people to repeat themselves?
   ☐Yes ☐No