Aegis Medical Center

Internal Medicine

Annual Wellness Form

Patient Name:_____ **DOB:** _____ **Date:**_____

1. Have you had any changes to your family history?
   - Yes
   - No

   _____

   _____

   _____

1. Any new surgeries? _____

   _____

2. During the 4 weeks, how much have you been bothered by the following problems- feeling anxious, depressed, irritable, sad or downhearted and blue?
   - Not at all
   - Slightly
   - Moderately
   - Quite a bit
   - Extremely

3. During the past 4 weeks, have you had little interest and pleasure in doing things?
   - Not at all
   - Slightly
   - Moderately
   - Quite a bit
   - Extremely

4. During the past 4 weeks, how much bodily pain have you generally had?
   - No pain
   - Very mild pain
   - Mild pain
   - Moderate pain
   - Severe pain

5. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, help with chores, if you were Sick, or needed help just taking care of yourself?
   - Yes, as much as I wanted
   - Yes, quite a bit
   - Yes, some
   - Yes, a little
   - No, not at all

6. 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

7. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)
   - Yes
   - No

8. Can you go shopping for groceries or clothes without someone's help?
   - Yes
   - No

9. Can you prepare your own meals?
   - Yes
   - No

10. Can you do your housework without help?
    - Yes
    - No

11. Because of any health problems, do you need the help of another person with your personal care needs

such as eating, bathing, dressing, or getting around the house?
- Yes
- No

12. Can you handle your own money without help?
    - Yes
    - No

13. During the past four weeks, how would you rate your health in general?
    - Excellent
    - Very good
    - Good
    - Fair
    - Poor

14. How have things been going for you during the past four weeks?
    - Very well
    - Pretty well
    - Good and bad parts about equal.
    - Pretty bad
    - Very bad

15. Are you having difficulties driving your car?
    - Yes, often
    - Sometimes
    - No
    - Not applicable, I do not use a car.

16. Do you always fasten your seat belt when you are in a car?
    - Yes, always
    - Yes, sometimes.
    - No

17. How often during the past four weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often
Falling or dizzy when standing up				
Sexual problems				
Trouble eating well				
Problems with teeth or dentures				
Problems when using the phone				
Tiredness or fatigue				

18. Have you fallen two or more times in the past year?
    - Yes
    - No

19. Are you afraid of falling?
    - Yes
    - No

20. Do you have difficulty getting out of chair or car without assistance?
    - Yes
    - No

21. Do you use a cane or walker?
    - Yes
    - No

22. Do you have any problems with your vision?
    - Yes
    - No

23. Do you have problems with your hearing?
    - Yes
    - No

24. Are you worried about your memory?
    - Yes
    - No

25. How often has confusion or memory loss interfered with your ability to work or affect home life?

    _____

26. In the past 30 days, how often has a family member provided care/assistance for you because of confusion or memory loss?

    _____

27. Are you a smoker?
    - Former smoker
        - How long?

          _____
        - Quit?

          _____
    - No
    - Yes , how may packs per day

      _____

28. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?
    - 10 or more drinks per week
    - 6-9 drinks per week. 2-5 drinks per week
    - One drink or less per week.
    - Non-drinker

29. Do you drink caffeine?

- Yes, how many per day?
  _____
- No

30. Do you use marijuana, any recreational drugs or used needles to inject drugs?
    - Yes,
      list_____
    - No
    - Have you ever taken someone's else's' drugs?
        - Yes
        - No

31. Do you exercise for about 20 minutes three or more days a week?
    - Yes, most of the time.
    - Yes, some of the time
    - Does not exercise

32. 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.

33. How confident are you that you can control and manage most of your health problems?
    - Very confident
    - Somewhat confident
    - Not very confident

34. Do you have advanced directives?
    - Yes
        - Health care power of attorney
        - Living will
        - DNR
    - No

Revised 12-13-2023

Vaccines: Reviewed with patient and the following vaccines

- Tdap
- Shingrix
- Prevanr 20
- Prevnar 13
- Pneumovax
- Flu
- Other:
  _____

Screenings:

Colonoscopy: Last date: _____

Where:_____

Mammogram: Last date: _____

Where: _____

Bone Density: Last date: _____

Where: _____

Eye Exam: Last date: _____

Where: _____:

Pap Smear: Last date:_____

Where: _____

Reviewed and completed by:

Date: _____

Clinic staff:

_____

Patient Signature:

_____