Aegis Medical Center

Internal Medicine

Annual Wellness Form

ient Name:	DOB:	Date:
Have you had any changes to your family history? Yes No	help you if you nee example, help with	
Any new surgeries?		
 During the <u>4 weeks</u>, how much have you been bothered by the following problems- feeling anxious depressed, irritable, sad or downhearted and blue? Not at all Slightly Moderately 	physical activity yo n	weeks, what was the hardest ou could do for at least 2 minutes?
Quite a bitExtremely		aces out of walking distance withou ble, can you travel alone on buses r own car?)
 3. During the past 4 weeks, have you had little interest and pleasure in doing things? Not at all Slightly 	YesNo	
ModeratelyQuite a bitExtremely	8. Can you go shopp someone's help?YesNo	ing for groceries or clothes without
 4. During the past <u>4 weeks</u>, how much bodily pain have you generally had? No pain Very mild pain Mild pain 	9. Can you prepare y ○ Yes ○ No	your own meals?
Moderate painSevere pain	10. Can you do your h ○ Yes ○ No	nousework without help?

11. Because of any health problems, do you need the

help of another person with your personal care needs

O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own money without help? O Yes O No Can you handle your own world ifficulty getting out of chair or car without assistance? O Yes O No Can you bave difficulty getting out of chair or car without assistance? O Yes O No Can you be a cane or walker?								
Can you handle your own money without help? O Yes No No During the past four weeks, how would you rate your health in general? Excellent Very good Good Fair Poor How have things been going for you during the past four weeks? No No Wery well Good and bad parts about equal. Pretty bad Pretty bad Pretty bad No Are you having difficulties driving your car? Yes, onsetimes No No Are you having difficulties driving your car? Yes, always Yes, sometimes. No No 20. Do you have any problems with your vision? Yes No 22. Do you have any problems with your vision? Yes No 23. Do you have problems with your hearing? Yes No No 24. Are you worried about your memory? Yes No No 25. How often has confusion or memory loss interfered with your ability to work or affect home life? No No Yes, always Yes, sometimes. No Yes, sometimes. No O Yes, always Yes, sometimes. No Yes, always Yes, sometimes. No Problems with pour seat belt when you are in a car? No Yes, always Yes, sometimes. Do you always fasten your seat belt when you are in a car? No Yes, always Yes, sometimes. Do you always fasten your seat belt when you are in a car? No Yes, how may packs per day Problems when using the phone 28. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverageed did you have? 10 or more drinks per week G-9 drinks per week Care drinks ruses a cane or walker? Yes No No Yes No No Yes No No Yes During the past four weeks, how many drinks of wine, beer, or other alcoholic beverageed did you have? 10 or more drinks per week G-9 drinks per week Care drinks ruses a cane wash	such as eating, bathing, dressing, or the house?	gett	ing a	arou	nd		(o No
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Falling or dizzy when standing up Sexual problems Trouble eating well Problems with teeth or dentures Problems when using the phone 28. During the past <u>four weeks</u> , how many drinks of wine, beer, or other alcoholic beverages did you have? ○ 10 or more drinks per week ○ 6-9 drinks per week ○ One drink or less per week		ever	opl	me	ten		(Yes , how may packs per day
Sexual problems Trouble eating well Problems with teeth or dentures Problems when using the phone 28. During the past <u>four weeks</u> , how many drinks of wine, beer, or other alcoholic beverages did you have? ○ 10 or more drinks per week ○ 6-9 drinks per week ○ One drink or less per week		ž	Se	So	<u>ğ</u>			
Trouble eating well Problems with teeth or dentures Problems when using the phone beer, or other alcoholic beverages did you have? ○ 10 or more drinks per week ○ 6-9 drinks per week ○ One drink or less per week						20	Г	During the pact four weeks, how many drinks of wine
Problems with teeth or dentures Problems when using the phone 0 10 or more drinks per week 0 6-9 drinks per week 0 One drink or less per week			20.					
Problems when using the phone o 6-9 drinks per week. One drink or less per week								· · · · · · · · · · · · · · · · · · ·
One drink or less per week					•			
	Problems when using the phone Tiredness or fatigue							

18. Have you fallen two or more times in the past year?

o Yes

Tiredness or fatigue

12.

13.

14.

15.

16.

17.

Non-drinker

	0	Yes, how many per day?	Vaccines: Revi	ewed with patient and the following vaccines	
	_	No No	Tdap		
	0	INO	Shingr	ix	
30.	Do	you use marijuana, any recreational drugs or used	Prevar		
		edles to inject drugs?	 Prevna 		
	0	Yes,	PneumFlu	novax	
		list	o Flu o Other:		
	0	No	o outon		
	0	Have you ever taken someone's else's' drugs? O Yes	Carraninas		
		o No	Screenings:		
			Colonoscopy:	Last date:	
31.		you exercise for about 20 minutes three or more		Where:	
	•	rs a week?			
		Yes, most of the time.	Mammogram:	Last date:	
	0	Yes, some of the time Does not exercise		Where:	
	O	Does not exercise	Bone Density:	Last date:	
32.		w often do you have trouble taking medicines the	20110 201101191		
		y you have been told to take them? I do not have to take medicine		Where:	
	0	I always take them as prescribed.	Eye Exam:	Last date:	
	0	Sometimes I take them as prescribed.		Where:	
	0	I seldom take them as prescribed.	Pap Smear:	Last date:	
22	Ца	w confident are you that you can control and	r up omoun		
JJ.		nage most of your health problems?		Where:	
	0	Very confident			
	0	Somewhat confident			
	0	Not very confident			
34	Dο	you have advanced directives?			
•	0	Yes			
		 Health care power of attorney 			
		 Living will 			
		o DNR			
	0	No			
Revised	12-1	3-2023			
			Reviewed and completed by:		
			Date:		
			Clinic staff:		
			Patient Signatur	re:	