Annual Wellness Update

Today's date: _____/_____/_____

Your name: _____

Your date of birth: _____/_____/_____

Please complete this checklist with the marker provided.

Your responses will give us valuable information to help you stay in the best health possible.

1. **Is there someone who is available to help you if you need help?**
   (For example, if you felt nervous, lonely, or needed to talk to someone; if you got sick and had to stay in bed, is there someone who could help you take care of yourself.)
   - ☐ Yes, as much as I want
   - ☐ Yes, sometimes
   - ☐ No, not at all

2. **How often do you have trouble taking your medicine the way your doctor has instructed you to?**
   - ☐ I cannot take them as instructed
   - ☐ Sometimes I take them as instructed
   - ☐ I always take them as instructed
   - ☐ I do not take any medicine

3. **Can you go shopping for groceries or clothes without help?**
   - ☐ Yes
   - ☐ No

4. **Do you need help from another person with your personal care needs such as eating, bathing, using the toilet, dressing, or getting around the house?**
   - ☐ Yes
   - ☐ No

5. **Can you prepare your own meals?**
   - ☐ Yes
   - ☐ No

6. **Have you prepared an Advanced Directive, a Living Will or Do Not Resuscitate Order?**
   - ☐ Yes
   - ☐ No, but would like to discuss

7. **How often does pain interfere with your activities of daily living?**
   - ☐ All the time
   - ☐ Daily
   - ☐ Less often than daily
   - ☐ Not at all
   - ☐ I never experience any type of pain

8. **Are you a smoker?**
   - ☐ No
   - ☐ Yes, and I am interested in quitting
   - ☐ Yes, but I am not ready to quit

9. **During the past *four weeks*, I have had…**
   - ☐ 10 or more drinks per week
   - ☐ 6-9 drinks per week
   - ☐ 2-5 drinks per week
   - ☐ 1 drink per week
   - ☐ I have not had any alcoholic drinks

10. **Have you had a fall in the past year?**
    - ☐ No
    - ☐ Yes, I have fallen, but did not get injured
    - ☐ Yes, I have had an injury due to a fall

11. **Are you afraid of falling?**
    - ☐ Yes
    - ☐ No

12. **During the past *four weeks*, I have been bothered by the following problems…**
    - ☐ Dizziness and lightheadedness
    - ☐ Tiredness
    - ☐ Sexual problems
    - ☐ Trouble eating
    - ☐ Trouble with my dentures
    - ☐ Money problems
    - ☐ I **have not** been bothered by any problems

13. **During the past *four weeks*, how much have you been bothered by problems such as feeling anxious, depressed, irritable, sad, or downhearted or blue?**
    - ☐ Not at all
    - ☐ Slightly
    - ☐ Quite a bit
    - ☐ Extremely

14. **During the past *four weeks*, has your physical and emotional health limited your social activities with family, friends or neighbors?**
    - ☐ Not at all
    - ☐ Slightly
    - ☐ Quite a bit
    - ☐ Extremely

15. **Have you received a Flu shot in the past 12 months?**
    - ☐ Yes, _____ (insert date)
    - ☐ No

16. **Have you ever received a Pneumonia shot?**
    - ☐ Yes, _____(insert date)
    - ☐ No

17. **If you are 50-75, have you had a Colorectal Cancer Screening?**
    - ☐ Colonoscopy in the past 9 years
    - ☐ Stool tested for blood in the past 12 months
    - ☐ CT colonography in the past 4 years
    - ☐ Cologuard stool test in the past 2 years
    - ☐ I have not had a screening

18. **If you are a female and age 50-74, have you had a Mammography in the past 24 months?**
    - ☐ Yes, _____ (insert date)
    - ☐ No, but have scheduled the test
    - ☐ No, I do not plan to have the test

19. **How confident are you about your ability to control or manage your health problems?**
    - ☐ Not very confident
    - ☐ Somewhat confident
    - ☐ Very confident
    - ☐ I do not have any health problems

20. **How would you rate your health during the past 12 months?**
    - ☐ Poor
    - ☐ Fair
    - ☐ Good
    - ☐ Very good
    - ☐ Excellent

Please list the name, location and phone number of other Doctors and Nurse Practitioners who are also providing you with care.

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

Thank you for completing your Wellness Checklist. Please list any concerns you would like to discuss with your healthcare team.

_____

_____

_____

FALL SELF-ASSESSMENT TOOL

Every 20 minutes an older adult dies from a fall related injury. Falling is a common problem that can be avoided. Please complete this self-assessment tool to identify factors that will put you at risk for falling, speak with your doctor or nurse practitioner about any "YES" answers and take one of the patient handouts about steps you can take in your home to prevent falls.

FALL RISK FACTOR	YES	NO	WHAT YOU CAN DO TO PREVENT FALLS
I have fallen in the past year			People who have fallen once are likely to fall again
I have been advised to use a cane or walker to get around safely			If you were advised to use a cane or walker, make sure you do so, as you are more likely to fall
I steady myself by holding onto furniture when walking at home			Unsteadiness or needing support while walking are signs of poor balance. You may benefit from an exercise program. As your doctor or nurse practitioner for more information
I need to push with my hands to stand up from a chair			
I have some trouble using stairs			
I am worried about falling			People who worry about falling are more likely to fall
I often have to rush to the toilet			Rushing to the bathroom, especially at night, increases your chance of falling
I have lost some feeling in my feet			Numbness in your feet can cause you to stumble and lead to falls
I take medicine that sometimes makes me feel light-headed or more tired than usual			Side effects from these medications can sometimes increase your chance of falling. Talk to your doctor or nurse practitioner if you have concerns or have difficult taking them as prescribed
I take medicine to help me sleep or improve my mood			These medications can sometimes increase your chance of falling. Review your medications with your doctor or nurse practitioner at least once every year
I often feel sad or depressed			Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Please circle the number)

	Not at all	Several days	More than half the days	Nearly every day
Little interest tor pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite; being fidgety and restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Total:_____

If you checked off any problems, how difficult have these problems made it for you to work, take care of things at home, or get along with other people?

☐ Not difficult at all

☐ Somewhat difficult

☐ Very difficult

☐ Extremely difficult

HEARING SCREENING QUESTIONNAIRE

Answer “Yes” or “No” to each question, by checking the answer that is correct for you

	YES	NO
Do you have a problem hearing over the phone?		
Do you have trouble following the conversation when two or more people are talking at once?		
Do people complain that you turn the TV volume up too high?		
Do you have to strain to understand conversation?		
Do you have trouble hearing when there is noise in the background?		
Do you find yourself asking people to repeat themselves?		
Do many people you talk to seem to mumble, or not speak clearly?		
Do you misunderstand what others are saying and respond inappropriately?		
Do you have trouble understanding the speech of women and children?		
Do people get annoyed because you misunderstand what they say?		

If you answered “Yes” to three or more questions, you will probably want to take the next step and have your hearing professionally tested. A hearing examination is also recommended if you hear ringing, roaring, or hissing sounds a lot, or if some ordinary sounds are painfully loud to you, or if you or your family have any concerns about your hearing ability.

URINARY QUESTIONNAIRE

Score key: 0 = not at all; 1 = less than 1 in 5; 2 = less than half the time; 3 = about half the time; 4 = more than half the time; 5 = almost always.

	Not at all	Less than 1	Less than half the time	About half the time	More than half the time	Almost always
Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
Over the past month, how many times did you most typically get up to urinate from the time you went to bed a night until the time you got up in the morning?	0 (never)	1 1 time	2 2 times	3 3 times	4 4 times	5 5 or more times

Total:_____

ALCOHOL USE QUESTIONNAIRE

Answer “Yes” or “No” to each question, by checking the answer that is correct for you

	Yes	No
When talking with others, do you ever underestimate how much you drink?		
After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn’t feel hungry?		
Does having a few drinks help decrease your shakiness or tremors?		
Does alcohol sometimes make it hard for you to remember parts of the day or night?		
Do you usually take a drink to relax or calm your nerves?		
Do you drink to take your mind off your problems?		
Have you ever increased your drinking after experiencing a loss in your life?		
Has a doctor or nurse ever said they were worried or concerned about your drinking?		
Have you ever made rules to manage your drinking?		
When you feel lonely, does having a drink help?		

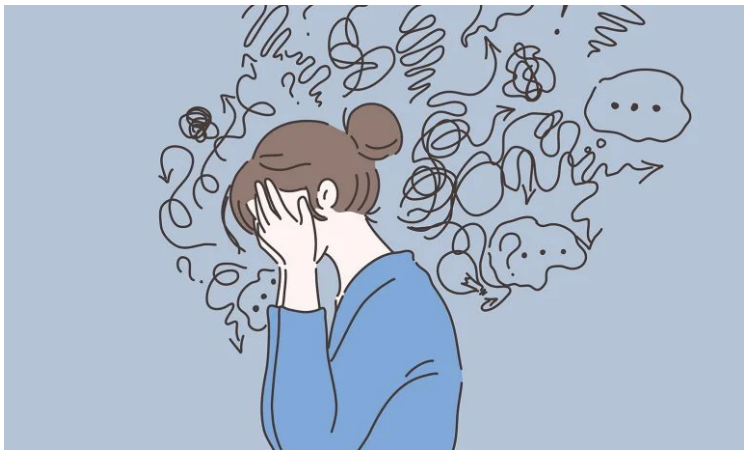
Score: If you answered “Yes” to two or more questions, you may have a drinking problem. Please talk to your doctor or nurse about this.

ANXIETY QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by the following problems? (Please circle the number)

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

Total: _____



Social Determinants

Social and economic issues can impact your health. Because of this, we are interested in knowing whether you have any concerns that might need to be addressed by helping with these concerns. Please answer the following questions so that we can understand how we can best help you address your medical records

1. **What is your housing situation today?**

   ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a care, abandoned building, bus or train station, or in the park)
   ☐ I have housing today, but I am worried about losing housing in the future
   ☐ I have housing

2. **Think about the place you live. Do you have any problems with any of the following? (check all that apply)**

   ☐ Bug infestation
   ☐ Mold
   ☐ Lead paint or pipes
   ☐ Inadequate heat
   ☐ Oven or stove not working
   ☐ No or not working smoke detectors
   ☐ Water leaks
   ☐ None of the above

3. **Within the past 12 months, you worried that your food would run out before you got money to buy more.**

   ☐ Often true
   ☐ Sometimes true
   ☐ Never true

4. **Within the past 12 months, the food you bought didn't last you and you didn't have money to get more.**

   ☐ Often true
   ☐ Sometimes true
   ☐ Never true

5. **In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)**

   ☐ Yes, it kept me from medical appointments or getting medications
   ☐ Yes, it kept me from non-medical meetings, appointments, work, or getting things that I needed
   ☐ No

6. **In the past 12 months has the electric gas, oil, or water company threatened to shut off services in your home?**

   ☐ Yes
   ☐ No
   ☐ Already shut off

7. **How often does anyone, including family, physically hurt you?**

   ☐ Never
   ☐ Rarely
   ☐ Sometimes
   ☐ Fairly often
   ☐ Frequently

8. **How often does anyone, including family, insult or talk down to you?**

   ☐ Never
   ☐ Rarely
   ☐ Sometimes
   ☐ Fairly often
   ☐ Frequently

9. **How often does anyone, including family, threaten you with harm?**

   ☐ Never
   ☐ Rarely
   ☐ Sometimes
   ☐ Fairly often
   ☐ Frequently

10. **How often does anyone, including family, scream or curse at you?**

    ☐ Never
    ☐ Rarely
    ☐ Sometimes
    ☐ Fairly often
    ☐ Frequently

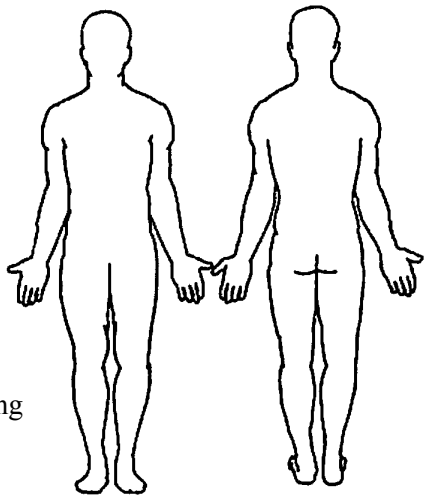
11. **Do you need any help?**

    ☐ Yes
    ☐ No

Visit date: _____/_____/_____

Your name: _____

Your date of birth: _____/_____/_____



Pain Questionnaire

1. **Where is your pain? Write in words or use the picture to show where.**
   _____
   _____

2. **Check off the words that describe your pain.**

☐ Aching	☐ Sharp	☐ Penetrating	☐ Stabbing	☐ Exhausting
☐ Throbbing	☐ Tender	☐ Nagging	☐ Miserable	☐ Gnawing
☐ Shooting	☐ Burning	☐ Numb	☐ Tiring	☐ Unbearable

3. **Does your pain occur occasionally, frequently or is it constant?** (Circle one)
   Occasionally Frequently Constant

4. **Rate your pain by circling the number that best describes your pain right now.**
   No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. **What makes your pain *better*?**_____
   What makes your pain *worse*?_____
   Examples: Causes/Increases in Pain:
   Movement Coughing Cold Heat Fatigue Anxiety Other

6. **What treatment or medication are you receiving for your pain?** If you are not receiving any treatment or medication, circle *NONE*. _____ NONE

7. **What relieves your pain:**

☐ Cold	☐ Heat	☐ Exercise	☐ Eating	☐ Opioids	☐ Non-Opioid Meds
☐ Adjuvants	☐ Herbals	☐ Massage	☐ Relaxation	☐ Rest	☐ Repositioning
☐ Distraction	☐ Other:_____				

8. **Effects of Pain:**
   Rate how the pain has had an effect in each area in the past 24 hours:
   0 (no effect) 2 (mild effect) 5 (moderate effect) 10 (severe effect)

9. **Accompanying Symptoms (e.g., nausea)**

☐ Sleep Disturbance	☐ Appetite Change	☐ Physical Activity	☐ Change Mood/Behavior
☐ Concentration	☐ Relationship with Others	☐ Other_____	

10. **In the past 24 hours, how much have the medications or treatments eased your pain?**
    ☐ No relief ☐ Mild relief ☐ Moderate relief ☐ Relief ☐ Complete relief

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☐ No action plan required
☐Action plan required
Plan for Addressing Pain (check all that apply):
☐ Initiate/Refer to pain management ☐ Call Prescriber ☐ Medications prescribed
☐ Rehab referral (PT, OT, ST) ☐ Non-med intervention/education
☐ Other, describe:_____ Comments:_____