Today's Date: ____________________
Name: ___________________________
Date of Birth: ____________________

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Please fill out the health questionnaire and bring it with you to your appointment.

General questions

1. What is your height?

Feet ○ 3 ○ 4 ○ 5 ○ 6 ○ 7

Inches ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5
○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11

2. What is your weight? (*pounds*)

○ Under 100 ○ 100-125 ○ 126-150 ○ 151-175
○ 176-200 ○ 201-225 ○ Over 226

3. In general, how would you rate your overall health?

○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

4. Have you had a flu shot this year or are you planning to receive one this year? ○ Yes ○ No

When was the last time you had a:	*In the last year*	*In the last 2-4 years*	*In the last 5 years*	*In the last 10 years*	*Never*	*Not applicable*
5. Pneumonia Vaccine?	○	○	○	○	○	○
6. Breast cancer screening (Mammogram)?	○	○	○	○	○	○
7. Colorectal cancer screening (Colonoscopy)?	○	○	○	○	○	○
8. Cervical cancer screening (PAP Smear)?	○	○	○	○	○	○

9. Do you exercise regularly or take part in a physical exercise program?

○ Yes, daily ○ Yes, more than 3 times a week ○ Yes, fewer than 3 times a week ○ No

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Your Health

10. What medical conditions do you have or have you had in the past? *(Please indicate all that apply)*

- ○ Anxiety
- ○ Asthma
- ○ Bi-polar disorder
- ○ Cancer: ___________
- ○ COPD/emphysema
- ○ Coronary heart disease
- ○ Dementia
- ○ Depression
- ○ Diabetes
- ○ Hearing problems
- ○ Hearth failure
- ○ Hypertension
- ○ Organ transplant
- ○ Renal/kidney failure
- ○ High cholesterol
- ○ Stroke
- ○ Vision Problems
- ○ Obesity
- ○ Thyroid disease
- ○ Other:_____________
- ○ None

11. Which of the following are you currently receiving treatment for? *(Please indicate all that apply)*

- ○ Anxiety
- ○ Asthma
- ○ Bi-polar disorder
- ○ Cancer: _____________
- ○ COPD/emphysema
- ○ Coronary Heart Disease
- ○ Dementia
- ○ Depression
- ○ Diabetes
- ○ Hearing problems
- ○ Heart failure
- ○ Hypertension
- ○ Organ transplant
- ○ Renal/kidney failure
- ○ High cholesterol
- ○ Stroke
- ○ Vision problems
- ○ Obesity
- ○ Thyroid disease
- ○ Other: ______________
- ○ None

12. How many medications do you take? ○ 0 ○ 1-3 ○ 4-5 ○ 6-7 ○ 8+

13. Do you use a pillbox to organize your medications? ○ Yes ○ No

14. Have you fallen more than once in the last 12 months? *(A fall is when your body goes to the ground without being pushed)* ○ Yes ○ No

15. If so, have you had an injury from a fall in the last year? ○ Yes ○ No

16. In the past 3 months, how many times did you go to the Emergency Room?

○ 0 ○ 1 ○ 2 ○ 3 or more

17. In the past 6 months, how many times have you had unplanned overnight stays as a patient in a hospital?

○ 0 ○ 1 ○ 2 ○ 3 or more

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	Yes	No
18. Has your provider recently told you that you need to lose weight?	○	○
19. Are you on a special diet recommended by your provider *(low sodium, low cholesterol, low fat)*?	○	○

20. In the past 7 days, how many servings of **fruits** and **vegetables** did you typically eat each day? *(1 serving=1cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup= size of a baseball.)*

○ 0 ○ 1-2 ○ 3 ○ 4+

21. In the past 7 days, how many servings of **high fiber** or **whole grain** foods did you typically eat each day? *(1 serving= 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)*

○ 0 ○ 1-2 ○ 3-4 ○ 5+

22. In the past 7 days, how many servings of **fried** or **high-fat** foods did you typically eat each day? *(Examples include friend chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream cheese, or mayonnaise.)*

○ 0 ○ 1 ○ 2-3 ○ 4+

23. In the past 7 days, how many sugar sweetened *(not diet)* beverages did you typically consume each day?

○ 0 ○ 1 ○ 2-3 ○ 4+

24. When was the last time you smoked or used any tobacco products? *(cigarettes, chew, snuff, pipes, cigars, vapor cigarettes)*

○ Never ○ Today ○ Yesterday ○ Last week

○ Last month ○ Last year ○ Longer than 5 years ago ○ Longer than 15 years ago

25. If you currently smoke or chew, how much do you smoke or chew per day? ______________/day

26. Are you interested in quitting? ○ Yes ○ No ○ Not applicable

27. Do you use any street drugs or abuse medications? ○ Yes ○ No

28. Do you drink alcohol? ○ Yes ○ No If yes, how many drinks per day? _______

29. What is the highest grade or level of school that you completed?

○ 8th grade or less ○ Some high school, but did not graduate ○ High school graduate or GED

○ Some college or 2 year degree ○ 4 year college graduate ○ More than a 4 year college degree

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Do you need help doing and of the following?

	Yes	No
30. Standing up from a sitting position?	○	○
31. Walking outside of the house?	○	○
32. Eating a meal?	○	○
33. Bathing?	○	○
34. Organizing your day?	○	○

	Yes	No
35. Walking in the house?	○	○
36. Preparing a meal?	○	○
37. Getting dressed?	○	○
38. Using the toilet?	○	○
39. Driving or getting to places?	○	○

40. If you answered "Yes" to **any** of the above questions, do you have someone who can assist you? ○ Yes ○ No

41. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

○ Always ○ Usually ○ Sometimes ○ Never

42. Do you have trouble hearing the TV or radio when others don't? ○ Yes ○ No

43. Do you have to strain or struggle to hear/understand conversations? ○ Yes ○ No

	Yes	No
44. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?	○	○
45. In the last 12 months, has your utility company shut off your service for not paying your bills?	○	○
46. Are you worried that in the next 2 months, you may not have stable housing?	○	○
47. In the last 12 months, have you needed to see a doctor, but could not because of cost?	○	○
48. In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	○	○
49. Are you afraid you might be hurt in your apartment building or house?	○	○

50. If you answered "Yes" to **any** of these questions, would you like to any information on resources for assistance with these needs? ○ Yes ○ No

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Advanced Care Planning

51. Do you have a Medical Power of Attorney? *(Someone to make medical decisions for you in the event you are unable to.)* ○ Yes ○ No

52. Do you have a living will/advance directive? *(Documents that make your health care wishes known.)* ○ Yes ○ No

53. Is a copy of your advance directive on file at Tri Valley Health System? ○ Yes ○ No

54. Would you like more information on advance directives? ○ Yes ○ No

About You

My health is important to me.	Strongly Disagree	Disagree	Agree	Strongly Agree
55. I am ultimately the one responsible for taking care of my health and wellness.	○	○	○	○
56. It is important for me to take an active role in my health care.	○	○	○	○
57. I am confident I can prevent or reduce problems associated with my health.	○	○	○	○
58. I am confident I know when I need to seek medical care and when I am able to take care of myself.	○	○	○	○
59. I am confident I can talk to my provider about my health concerns even when he or she does not ask.	○	○	○	○
60. I am confident I can follow through on medical treatments I may need to do at home.	○	○	○	○

61. Who completed this survey? ○ Myself ○ Relative of mine ○ Friend of mine ○ Professional caregiver of mine

62. Do you live?
    ○ Alone ○ With other family member ○ Nursing home or assisted living facility
    ○ With spouse ○ With non-relative

63. In your house do you **have**? *(select all that apply)*
    ○ Handrails on stairs/steps ○ Good lighting ○ Tub/shower mat ○ Rugs
    ○ Functioning smoke alarms ○ Grab bars in bathroom ○ Tub/shower bench

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Current list of providers, specialists, and suppliers involved in your care:

Name	Specialty	Reason/Next Appointment

Family History: particularly parents, grandparents, and siblings suffer from any of the following. ***(check all that apply)***

- ○ Alcoholism
- ○ Cancer
- ○ High Cholesterol
- ○ Obesity
- ○ Arthritis
- ○ Diabetes
- ○ Hypertension
- ○ Stroke
- ○ Cancer
- ○ Heart Disease
- ○ Liver or Kidney Disease
- ○ Thyroid Disease
- ○ Other:____________________

Questions or concerns you would like to discuss at your Wellness Visit: