PRIMEHEALTH
WHERE CARE COMES TOGETHER

Annual Wellness Visit Questionnaire

Patient Name:_____
Date of Birth: _____

List any hospitalizations or visits to the emergency room

Date	Reason	Location

Medications or Allergies

Medication	Dose	Reason for Taking

Allergies	Reaction	Allergies	Reaction

Medical History

	Me	Father	Mother	Siblings	Children	Grandparents
Coronary Disease						
High Blood Pressure or Cholesterol						
Cerebral Vascular Disease / Stroke						
Renal Disease						
Cancer						
Diabetes						
Aortic Aneurysms						
Mental Health Conditions						
Illegal Drug/Substance Use						
Other:						

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Names of Providers / Specialists seen since your last visit

Doctor's Name	Specialty Type and Reason You See Them

Medical Equipment (Oxygen/Supplies/Home Health)

Supply	Who provides this service for you?

Health Risk Assessment

1. Over the last 4 weeks, how would you rate your health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor	
2. Do you eat 5 servings of fruits and vegetables a day?			☐ Yes	☐ No	
3. Do you exercise at least 20 minutes, 3 or more times a week?			☐ Yes	☐ No	
4. Are you or a family member concerned about your memory?			☐ Yes	☐ No	
5. Do you feel overly tired or fatigued often?			☐ Yes	☐ No	
6. Do you have any physical pain that limits your activities?			☐ Yes	☐ No	
7. Do you have trouble hearing?			☐ Yes	☐ No	
8. Does your home have rugs in the hallway?			☐ Yes	☐ No	
9. Do you have grab bars in the bathroom?			☐ Yes	☐ No	
10. Have you fallen in the last 12 months?			☐ Yes	☐ No	
11. Does your home have poor lighting?			☐ Yes	☐ No	
12. Do you have handrails on the stairs?			☐ Yes	☐ No	
13. In the last 4 weeks, have you had difficulty:					
☐ Walking	☐ Going up and down the stairs	☐ Standing up or sitting down	☐ Dressing	☐ Brushing teeth	
☐ Bathing or taking a shower	☐ Using the toilet	☐ Feeding yourself	☐ Managing medications	☐ Cooking	
☐ Housecleaning	☐ Laundry	☐ Using a computer	☐ Using the phone	☐ Managing finances or paying the bills	
☐ Using public transportation or driving	☐ Shopping				

14. On a scale of 1-10, what number best describes your pain on average?		☐
15. On a scale of 1-10, what number best describes how the pain has interfered with your enjoyment of life?		☐
16. On a scale of 1-10, what number best describes how the pain has interfered with your general activity?		☐
17. Do you have an advance directive?		
18. Do you have concerns about sexually transmitted infections?	☐ Yes	☐ No
19. Do you have a dental home?	☐ Yes	☐ No
20. What is your home environment? (e.g., assisted living, rent, own, roommate) _____		
21. Do you wear seatbelts?	☐ Yes	☐ No
22. Do you use sunscreen?	☐ Yes	☐ No