Annual Wellness Visit HRA – Please complete and bring with you the day of your appointment

Name_____ **Date of Birth** _____/_____/_____

Date and time of appointment_____ **Location**_____

Provider you are seeing_____

1.A - In General, would you say that your health is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2.A - Does handling such things as your health, finances, family, social relations, or work cause you stress? ☐ Yes ☐ No

2.B - If yes, do you get the social and emotional support you need? ☐ Yes ☐ No

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1.A - Over the last two weeks, how often have you been bothered by: Having little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

2.A - Over the past two weeks, how often have you been bothered by: feeling down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

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1.A - Do you currently live in an:

Independent/single family home ☐
Apartment ☐
Mobile home ☐
Assisted living apartment ☐
Nursing home ☐
Other ☐

1.B - Do you Live with anyone? ☐ Yes ☐ No

1.C - If yes, who do you live with? _____

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2.A - In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet? ☐ Yes ☐ No

3.A - In the past 7 days, have you had any problems with any constipation, or diarrhea?

☐ Yes ☐ No

4.A - In the past 3 months have you experienced any issues with bladder control or urine leakage?

☐ Yes ☐ No

5.A - In the past 7 days, did you need help from others to take care of such things as laundry and housekeeping, banking, shopping, using the phone, food preparation, or transportation?

☐ Yes ☐ No

6.A - Do you take medications? ☐ Yes ☐ No

6.B - If yes, do you need assistance taking, organizing, or paying for your medications? ☐ Yes ☐ No

7.A - Do you drive? ☐ Yes ☐ No

7.B - If yes, do you or your family, friends, or caregivers have any concerns about your ability to drive? ☐ Yes ☐ No

7.C - Do you consistently wear a seatbelt when in the car? ☐ Yes ☐ No

8.A - Does your home have any hazards you are concerned about such as throw rugs, poor lighting, or a slippery bathtub or shower? ☐ Yes ☐ No

8.B - Does your home have grab bars and/or handrails on the steps or stairs? ☐ Yes ☐ No

9.A - Have you fallen in the last 6 months? ☐ Yes ☐ No

9.B - If yes, did you sustain any injury? ☐ Yes ☐ No

9.C - Are the areas where you are walking well lit? ☐ Yes ☐ No

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1.A - Would you say your appetite is normal, decreased, or increased within the last six months?

☐ Normal ☐ Increased ☐ Decreased

1.B - Do you eat a variety of foods? ☐ Yes ☐ No

1.C - Do you take any nutritional supplements? ☐ Yes ☐ No

1.D - Have you had any unintentional weight gain or weight loss in the past months? ☐ Yes ☐ No

2.A - Do you see a dentist regularly? ☐ Yes ☐ No

2.B - Do you have any concerns with your oral health? ☐ Yes ☐ No

3.A - In the past 7 days, how many days did you exercise? _____

3.B - When you did exercise, for how long did you exercise (in minutes)? _____

4.A - Each night, how many hours of sleep do you usually get? _____

4.B - Do you snore or has anyone told you that you snore? ☐ Yes ☐ No

4.C - In the past 7 days, how often have you felt sleepy during the daytime? _____

5.A - Do you have trouble hearing the television or radio when others do not? ☐ Yes ☐ No

5.B - Do you have to strain or struggle to hear/understand conversations? ☐ Yes ☐ No

5.C - Do you wear hearing aids? ☐ Yes ☐ No

6.A - Do you see an eye doctor regularly? ☐ Yes ☐ No

6.B - Do you wear glasses and/or contacts? ☐ Yes ☐ No

6.C - Have you had any recent changes to your eyesight? ☐ Yes ☐ No

7.A - Do you have a Medical Power of Attorney (someone to make medical decisions for you in the event you are unable to)? ☐ Yes ☐ No

7.B - Do you have a living will or advanced directive? ☐ Yes ☐ No

7.C - If yes, can you provide a copy for your health care provider's office? ☐ Yes ☐ No

7.D - If no, or you are unsure, would you be interested in an appointment to discuss this with your usual provider? ☐ Yes ☐ No

Other concerns to discuss with your provider?