Annual Health Assessment Questionnaire

Patient Name:	Patient DOB:

About You	
1. What is your primary language?	
2. What is your ethnicity?	
3. What is the highest grade of school that you completed?	☐ 8th grade or less ☐ Some High School ☐ Some College ☐ High school Degree/GED ☐ Associates Degree ☐ Doctorate ☐ Bachelor's Degree ☐ Master's Degree
4. Who do you live with?	☐ Alone ☐ With Spouse ☐ With other family member(s) ☐ With non-relative(s) ☐ Nursing home/assisted living facility

General Health/Prevention						
5. How is your overall health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know					
6. How is your overall quality of life?	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know					
7. How is your social support?	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know					
8. In the past 3 months, how many times did you go to the Emergency Room?	☐ 0 ☐ 1 ☐ 2 ☐ 3+					
9. In the past 6 months, how many times have you had unplanned overnight stays as a patient in a hospital?	☐ 0 ☐ 1 ☐ 2 ☐ 3+					
10. Have you had a flu shot this year?	☐ Yes ☐ No					
11. If you answered no, are you planning on receiving one this year?	☐ Yes ☐ No					
12. 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	N/A
Pneumonia vaccine?	☐	☐	☐	☐	☐	☐
Prevnar 13?	☐	☐	☐	☐	☐	☐
Breast cancer screening (Mammogram)?	☐	☐	☐	☐	☐	☐
Colorectal cancer screening (Colonoscopy)?	☐	☐	☐	☐	☐	☐
Cervical cancer screening (PAP Smear)?	☐	☐	☐	☐	☐	☐
PSA?	☐	☐	☐	☐	☐	☐
Osteoporosis?	☐	☐	☐	☐	☐	☐
13. How is the health of your mouth & teeth?	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know					
14. Do you have a Medical Power of Attorney? (Someone to make medical decisions for you in the event you are unable to).	☐ Yes ☐ No ☐ Don't remember/don't know					
15. Do you have a living will/advanced directive? (Documents that makes your health care wishes known)	☐ Yes ☐ No ☐ Don't remember/don't know					
16. Is a copy of your advanced directive on file at your PCP's office?	☐ Yes ☐ No ☐ Don't remember/don't know					

Exercise & Nutrition:	
17. How many days a week do you exercise?	☐ None ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
18. On the days you exercised, how long did you exercise?	☐ 0-30min ☐ 30min-1 hour ☐ more than 1 hour ☐ I don't exercise
19. Are you on a special diet?	☐ Yes ☐ No

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20. In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? *(1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit; 1 cup = size of a baseball).*	☐ None ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
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)*	☐ None ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
22. In the past 7 days, how many servings of meat, fish, or other protein did you typically eat each day?	☐ None ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
23. In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? *(Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise)*	☐ None ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
24. In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?	☐ None ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
Sleep	
How many hours of sleep do you usually get?	☐ 0-3 ☐ 4-6 ☐ 7-10 ☐ 10+ ☐ I don't know
Do you snore or has anyone told you that you snore?	☐ Yes ☐ No
In the past 7 days, how often have you felt sleep in the daytime?	☐ Often ☐ Sometimes ☐ Almost Never ☐ Never ☐ I don't know
Tobacco Use	
Do you currently smoke, chew, or vape tobacco?	☐ Yes ☐ No ☐ Former Smoker
If you are a former smoker, how many years did you smoke?	☐ <5 ☐ 5-10 ☐ 10-15 ☐ 15-20 ☐ 25+
25. For current smokers, what products do you use? *(Check all that apply)*	☐ Cigarettes ☐ Chew ☐ Snuff ☐ Pipe ☐ Cigars ☐ Vape Cigarettes ☐ Vape Pen
26. Are you interested in quitting?	☐ Yes ☐ No
Alcohol Use	
27. How often do you have a drink containing alcohol?	☐ Never ☐ Monthly or less ☐ 2-4x/month ☐ 2-3x/week ☐ 4+ times a week
28. How many standard drinks containing alcohol do you have on a typical day?	☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10+
29. How often do you have 6 or more drinks on one occasion?	☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily/almost daily

Medication Usage	
30. How often do you take medications?	☐ Daily ☐ Weekly ☐ As needed ☐ Never
31. How many medications do you take?	☐ 0 ☐ 1-3 ☐ 4-5 ☐ 6-7 ☐ 8+
32. Do you find that sometimes you have to choose between buying groceries or medications?	☐ Yes ☐ No ☐ Sometimes

Cognitive Assessment
33. Word Recall Score: ☐ 3/3 words ☐ 2/3 words ☐ 1/3 words ☐ no words Clock Drawing: ☐ Passed ☐ Did not pass

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Fall Screening	
34. Have you had 2 or more falls within the past 12 months?	☐ Yes ☐ No
35. Have you had a fall with injury?	☐ Yes ☐ No
36. Do you have any problems with gait or balance?	☐ Yes ☐ No
Depression Screening	
37. In the past 2 weeks, have you had little interest or pleasure in doing things?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly everyday
38. In the past 2 weeks, have you been feeling down, depressed, or hopeless?	☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly everyday
Pain	
39. In the past 4 weeks, how much body pain have you had?	☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
40. In the past 4 weeks, how much did your pain interfere with your normal activities?	☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
41. During the past 4 weeks, how has your health impacted your ability to work or caused you to be absent from activities you enjoy?	☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely
42. How do you treat the pain?	☐ Medication ☐ Rest ☐ Heat/Cold ☐ Therapy ☐ No treatment Plan ☐ Other ☐ No pain

Activities of Daily Living:					
43. Do you need any help doing the following? *(please mark yes or no by each activity)*					
Activity	Yes	No	*Activity*	Yes	No
Standing up from a sitting position?	☐	☐	Walking in the house?	☐	☐
Walking outside of the house?	☐	☐	Preparing a meal?	☐	☐
Eating a meal?	☐	☐	Getting dressed?	☐	☐
Bathing?	☐	☐	Using the toilet?	☐	☐
Managing Medications?	☐	☐	Shopping?	☐	☐
Organizing you day?	☐	☐	Driving or getting to places?	☐	☐
Using the telephone?	☐	☐	Doing laundry?	☐	☐
44. If you answered 'yes' to any of the above questions, do you have someone who can assist you?			☐ Yes ☐ No Caregiver Name/Relationship:		
45. 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		
Ambulation Status:					
46. How long can you walk or move around?			☐ 0-5 min ☐ 5-15min ☐ 15-30min ☐ 30-60 min ☐ more than 1 hour		
47. Which of these assistive devices do you use?			☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Other ☐ None		
Sensory Abilities:					
48. Do you have problems with vision?			☐ Yes ☐ No ☐ Sometimes		
49. Do you use eyeglasses or contact lenses?			☐ Yes ☐ No		
50. Do you have problems with hearing?			☐ Yes ☐ No ☐ Sometimes		

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51. Do you have difficulty hearing when someone speaks in a whisper?	☐ Yes ☐ No ☐ Sometimes
52. Do you use hearing aids or other devices to help you hear?	☐ Yes ☐ No

Home/Safety:	
53. Please indicate which safety features you have installed in your home:	☐ Smoke alarm ☐ Carbon Monoxide Alarm ☐ Handles for shower/tub
54. Do you wear seatbelts when you ride in vehicles?	☐ Yes ☐ No ☐ I don't ride in vehicles
55. Please mark which of these you have in your house:	☐ Rugs ☐ Grab bars in bathroom ☐ Handrails ☐ Poor lighting
Social/Emotional Support:	
56. Which of the following applies to you:	☐ I have a supportive family ☐ I have supportive friends ☐ I participate in church, clubs, or other group activities ☐ None

Self & Family History					
Mark all the columns that apply	None	Self	Parent	Brother/Sister	Child
Anxiety	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Bipolar Disorder/Schizophrenia	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
COPD/Emphysema	☐	☐	☐	☐	☐
Coronary heart disease	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Organ Transplant	☐	☐	☐	☐	☐
Renal/kidney failure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Condition	☐	☐	☐	☐	☐
Urinary Incontinence	☐	☐	☐	☐	☐

Allergies	
57. Do you have any allergies (food or drugs)	☐ Yes ☐ No
58. If yes, please list the medications in the box:	

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Notes: Indicate here any information that patient would like discussed with provider at AWV/AHA visit

Medications Please list all medications in the boxes below			
Name of Mediation	Strength	Frequency	Prescribing Physician

Other Providers You See		
Specialty	Physician Name	Date Last Seen
Cardiologist		
Pulmonologist		
Eye Doctor		
Endocrinologist		
Dentist		
Dermatologist		
Gynecologist		
Ears, nose, and throat		