



Franciscan Healthcare

Annual Wellness Visit Questionnaire

To ensure optimal care coordination, please list all providers you see on a regular basis.

Providers involved in your Healthcare	Specialty

Medical Devices and Durable Medical Equipment- check all that apply

- None
- Implantable cardioverter- defibrillator
- Insulin Pump
- Medication Pump
- Pacemaker
- Other:
- Oxygen Therapy
- Walker
- Wheelchair
- Bed (hospital)
- CPAP
- Spirometry
- Splint
- Immobilizer
- Commode
- CGM

Diagnostic Screenings

- Have you had a colonoscopy? Yes No
- If yes, where was your colonoscopy performed? _____
- Women- have you had a mammogram? Yes No
- If yes, where was your mammogram performed? _____
- Have you had a DEXA Scan performed? Yes No
- If yes, where was your DEXA Scan performed? _____

Sleep

- Do you snore loudly? Yes No
- Do you often feel tired, fatigued, or sleepy during daytime? Yes No
- Has anyone observed you stop breathing while you're sleeping? Yes No
- Have you or are you being treated for high blood pressure? Yes No

Alcohol Use History

- Did you have a drink containing alcohol in the past year? Yes No
- If yes, how often did you have a drink containing alcohol in the past year?
- monthly or less 2 to 4 times a month 2 to 3 times per week 4 or more times a week
- If yes, how many drinks did you have on a typical day when you were drinking in the past year?
- 1 or 2 3 or 4 5 or 6 7 to 9 10 or more



Franciscan Healthcare

If yes, how often did you have six or more drinks on one occasion in the past year?

- never
- less than monthly
- monthly
- weekly
- daily or almost daily

Tobacco Use History

Have you or do you use smoking tobacco?

- Never
- Current
- Former

If former or current smoker, how many cigarettes per day average during time you smoked?

How many years have you or did you smoke?

Age Started _____ Age Stopped _____ # _____

Have you or do you use smokeless tobacco?

- Never
- Current
- Former

Have you or do you use electronic Cigarettes (Vaping)?

- Never
- Current
- Former

Have you or do you use Illicit Substances?

- Never
- Current
- Former

Health Risk Assessment

Are there hazards in your house that might hurt you?..... No Yes

Have you been given any information to help you with hazards in your house that might hurt you?..... No Yes

Have you fallen in the past year?..... No Yes

Are you worried you might fall?..... No Yes

Do you feel unsteady standing or walking?..... No Yes

Do you use a cane or a walker?..... No Yes

Do you need someone to help you get up in the morning?..... No Yes

In the past four weeks, have you fallen or felt dizzy when standing up?... No Yes

Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?..... No Yes

Do you have trouble consistently taking or remembering to take all of your medications as prescribed?..... No Yes

Can you get to places out of walking distance without help?..... No Yes

(For example, can you travel alone or drive your own vehicle?)

Can you go shopping for groceries or clothes without help?..... No Yes

Can you prepare your own meals?..... No Yes

Can you do your housework without help?..... No Yes

Can you manage your own money without help?..... No Yes



Franciscan Healthcare

Can you keep track of your own medications without help? No Yes

Have you been given any information to help with keeping track of your medications? No Yes

During the past four weeks, how would you rate your general health?

Excellent Very good Good Fair Poor

During the past four weeks, how much bodily pain have you generally had?

No pain Very mild pain Mild pain Moderate pain Severe Pain

During the past four weeks, how have things been going for you?

Very well Pretty well Good and bad parts about equal Pretty bad Very bad

During the past four weeks, was someone available to help you if you needed and wanted help?

Yes, as much as I wanted Yes, quite a bit Yes, some Yes, a little No, not at all

During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

Not at all Slightly Moderately Quite a bit Extremely

During the past four weeks, how often have you had trouble eating well?

Never Seldom Sometimes Often Always

During the past four weeks, how often have you had teeth or denture problems?

Never Seldom Sometimes Often Always

During the past four weeks, how often have you had problems using the telephone?

Never Seldom Sometimes Often Always

During the past four weeks, how often have you been bothered by sexual problems?

Never Seldom Sometimes Often Always

Are you having difficulties driving your vehicle?

Not applicable, I do not use a car No Sometimes Yes, often

Do you always wear your seat belt when you are in a vehicle?

I always fasten my seat belt I occasionally fasten my seat belt I never fasten my seat belt

How confident are you that you can control and manage most of your health problems?

I do not have any health problems Very Confident Somewhat Confident Not Very Confident



Franciscan Healthcare

Depression Screen

How often have you been bothered by the below symptoms over the last **2 weeks**?

- Little interest, pleasure in activities Not at all Several days More than half the days Nearly every day
- Feeling down, depressed, hopeless Not at all Several days More than half the days Nearly every day
- Trouble falling or staying asleep Not at all Several days More than half the days Nearly every day
- Feeling tired or little energy Not at all Several days More than half the days Nearly every day
- Poor appetite or overeating Not at all Several days More than half the days Nearly every day
- Feeling bad about yourself Not at all Several days More than half the days Nearly every day
- Trouble concentrating Not at all Several days More than half the days Nearly every day
- Moving or speaking slowly Not at all Several days More than half the days Nearly every day
- Thoughts better off dead or hurting self Not at all Several days More than half the days Nearly every day
- Difficulty at work, home, or getting along with others Not difficult at all Somewhat difficult Very difficult Extremely difficult

Function Screen

Indicate a level of assistance for each activity of daily living:

- Bathing: Independent Requires Assistance Dependent
- Dressing: Independent Requires Assistance Dependent
- Toileting: Independent Requires Assistance Dependent
- Transferring Bed or Chair: Independent Requires Assistance Dependent
- Continence: Independent Requires Assistance Dependent
- Feeding: Independent Requires Assistance Dependent

Advanced Directive

Do you have an Advanced Directive? Yes No

If yes, what type? Organ/ Tissue Donation Living Will Medical Durable POA

* Please bring a copy for us to place on file

Do you wish to receive further information on Advanced Directives?..... Yes No

Immunizations

Are you interested in a Shingles vaccine series?..... Yes No

Are you interested in a Covid vaccine series?..... Yes No

Do you need to update you Tdap or Pneumococcal vaccine?..... Yes No