Adult Patient Annual Wellness Questionnaire

Name: _____ **DOB:**_____ **Date:** _____

Past Medical History

☐ Hypertension ☐ Diabetes ☐ Asthma ☐ COPD ☐ Heart Disease
☐ Stroke/TIA ☐ Thyroid Disease ☐ kidney disease ☐ Liver Disease
☐ Cancer (type): _____ ☐ Autoimmune Disease: _____
☐ Mental Health Conditions: _____
☐ Other: _____

Surgical History (including year)

Current Medications (include dose & frequency)

Medication Dose Frequency

Allergies

☐ No known allergies
Medication / Food / Other: _____
Reaction: _____

Specialists (please provide name and specialty):

Family History – Cancer (please check all that apply)

Instructions: For each cancer checked, please list the **family member(s)** affected and the **age at diagnosis** (if known).

Cancer Type	Check ☐	Family Member(s) (e.g., mother, father, sibling, grandparent)	Age at Diagnosis
Breast cancer	☐		
Colon / Colorectal cancer	☐		
Ovarian cancer	☐		
Prostate cancer	☐		
Endometrial (uterine) cancer	☐		
Pancreatic cancer	☐		
BRCA 1 or BRCA 2 mutation	☐		
Lynch syndrome (HNPCC)	☐		

Other cancers or genetic conditions in family:

Social History and Safety

Tobacco: ☐ Never ☐ Former; Quit date: _____ ☐ Current ; packs per day: _____ # of years: _____ ☐ Chewing ☐ Pipe ☐ Dip; how much: _____
Alcohol: ☐ None ☐ 0-1 a month ☐ 2-4/month ☐ Weekly ☐ Daily

Each week how many servings of alcohol: _____

When did you last have 4 serving of alcohol in one sitting? _____

Do you feel you should cut down on drinking alcohol? _____

Do people annoy you by nagging you to cut down? _____

Have you felt guilty about drinking _____

Have you ever had to have a morning drink to steady your nerves? _____

Recreational Drugs: ☐ None ☐ Current (specify): _____☐ Previous (specify)_____ Last use? _____ ☐ Needle use?_____
Occupation: _____
Exercise: ☐ None ☐ 1–2x/week ☐ 3–5x/week ☐ Daily

Personal Safety:

Do you wear seat belts? ___ Do you have frequent falls? _____ Do you experience conflict in relationships leading to verbal, emotional, physical, or sexual abuse? _____

Sexual Health:

☐ Sexually active ☐ Not currently ☐Never | # of partners in past year:

History of sexually transmitted infection: ☐yes ☐ no Type/date: _____

Current contraceptive method: _____

# of living children:

***Women only**: # of pregnancies____ # of miscarriages _____# of abortions _____

Still having periods? _____ circle one: Regular/irregular, Heavy/light, very painful/manageable, of days _____ Age periods started: _____

Age periods ended: _____ Hysterectomy? _____ if yes; total/partial/unknown? _____ Do you still have a cervix? _____

Review of Systems (check all that apply)

☐ Fever/Chills ☐ Fatigue ☐ Weight Change
☐ Chest Pain ☐ Shortness of Breath ☐ Palpitations
☐ Abdominal Pain ☐ Nausea/Vomiting ☐ Diarrhea/Constipation
☐ Headache ☐ Dizziness ☐ Depression/Anxiety
☐ **Memory problems or changes in thinking**
☐ Other: _____

Memory / Cognitive Concerns (please complete if checked above)

Describe the problem: _____

When did you first notice this? _____
Is it getting worse? ☐ No ☐ Yes ☐ Unsure
Examples (forgetting appointments, names, directions, etc.):

Has anyone else noticed changes? ☐ No ☐ Yes (who?): _____
Impact on daily activities: ☐ None ☐ Mild ☐ Moderate ☐ Severe

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Preventive Care

Instructions for patients:
Please list the most recent date you had each screening and whether the result was normal or abnormal (if known).
If you have never had the test, it **<u>may be</u>** recommended today as part of your wellness visit. Please check the box if you are interested in discussing this today.

Cancer Screening

Screening	**Last Date**	**Result (Normal/Abnormal)**	**Interested Today ☐**
Breast cancer – Mammogram	_____	☐normal ☐abnormal	☐
Cervical cancer – Pap / HPV	_____	☐normal ☐abnormal	☐
Colorectal cancer – Stool test / Colonoscopy	_____	☐normal ☐abnormal	☐
Lung cancer – Low-dose CT *(Adults 50–80 with ≥20 pack-year history, current smoker or quit <15 yrs)*	_____	☐normal ☐abnormal	☐

Infectious Disease Screening

Screening	Last Date	Result (N/Abnl)	Interested Today ☐
HIV screening	_____	☐normal ☐abnormal	☐
Hepatitis C screening (adults 18–79)	_____	☐normal ☐abnormal	☐
Hepatitis B screening (if risk factors)		☐normal ☐abnormal	☐
Syphilis screening (if risk factors)		☐normal ☐abnormal	☐
Gonorrhea / Chlamydia screening (if risk factors)		☐normal ☐abnormal	☐

Bone & Vascular Health

Screening	Last Date	Result (N/Abnl)	Interested Today ☐
Osteoporosis screening – DEXA			☐
Abdominal Aortic Aneurysm screening *(Men age 65–75 who have ever smoked)*			☐
Fall risk assessment (age ≥65 or risk factors)			☐

Vaccines (ACIP – patient reported)

Please list last known date if available.

Vaccine	Last Date	Interested Today ☐	Vaccine	Last Date	Interested today
Influenza	_____	☐	Tdap / Td	_____	☐

Vaccine	Last Date	Interested Today ☐	Vaccine	Last Date	Interested today
COVID-19	_____	☐	Shingles (Zoster)	_____	☐
HPV	_____	☐	Pneumococcal	_____	☐
Hepatitis B	_____	☐			

Patient Signature

I certify that the information provided is accurate to the best of my knowledge.

Signature: _____ **Date:** _____

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