NEWPORT FAMILY MEDICINE 520 Superior Drive Suite 360
Newport Beach CA 92663 (949) 644-1025 FAX (949) 644-7852

Annual Wellness Exam Questionnaire

Patient Name: _____ **Date:** _____

Patient or Guardian Signature _____

Print name of Guardian _____

Patient Date of Birth _____ **Patient Age** _____ **Male / Female**

Please provide a list of all other physicians you currently see or have seen this year:

Name	**Specialty**	**Reason**

Please provide a list of all vendors you obtain medical supplies from:

_____

_____

_____

_____

Please provide a list of all medications you currently take including over the counter supplements:

_____ Dose _____ Frequency _____

_____ Dose _____ Frequency _____

_____ Dose _____ Frequency _____

_____ Dose _____ Frequency _____

_____ Dose _____ Frequency _____

_____ Dose _____ Frequency _____

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Hearing	**Circle Response**
Do you have trouble hearing the TV or telephone when others do not?	Yes No
Do you have to strain to hear/understand conversations?	Yes No

Home Safety

Does your home have "throw" rugs?	Yes No
Do you use a non-slip bath mat in the tub or shower?	Yes No
Do you have handrails on all steps and stairs?	Yes No
Does your home have working smoke detectors?	Yes No

Balance

Have you had a fall in the last year or feel unsteady on your feet?	Yes No

Daily Routine

Do you live alone?	Yes No

Do you need help with any of the following? (Please circle all that apply)

Preparing meals Shopping Driving/transportation Bathing

Walking distances Managing your finances

Cognitive Health

Do you have any concerns about your memory or other cognitive functions?	Yes No

Please circle any of these tasks that you are having difficulty with:

Remembering to take medication Recalling past events Recalling names Word retrieval

Recalling historic events or dates Getting lost while driving Remembering appointments

Completing Complex tasks (preparing taxes, planning projects, balancing the checkbook)

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Patient Name: _____ **Date:** _____

Compared to 10 years ago, my memory is: (circle response)

A lot worse	A little better
A little worse	A lot better
About the same (no change)	Not Certain

How are you feeling?

During the past 4 weeks, have you been bothered by emotional problems

such as feeling anxious, depressed, irritable, sad or downhearted and blue? Yes No

Have you lost interest in activities you usually enjoy? Yes No

Have you had a loss or increase in your appetite? Yes No

Have you had any problems with insomnia or sleeping excessively? Yes No

Are you a smoker?

Yes _____ No _____ Yes, but I'm ready to quit _____

During the PAST 4 WEEKS, how many drinks of wine, beer or other alcoholic beverages did you have?

None _____ 1 drink or less per week _____ 2-5 per week _____

6-9 per week _____ 10 or more per week _____

Vision Assessment

Have you seen an optometrist or ophthalmologist in the last year? Yes No

If not, we will have one of our staff check your vision today:

	Uncorrected	Corrected
Right Eye (OD)	_____	_____
Left Eye (OS)	_____	_____
Both eyes (OU)	_____	_____

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Patient Name: _____ **Date:** _____

Health Screening Exams

Please list the date and findings of your most recent:

Colonoscopy _____

PSA and Rectal exam (males) _____

Mammogram/Pap Smear (females) _____

Bone Density test (DEXA) _____

Vaccines

Please list the date you last received this vaccine:

Tetanus: Td (Tetanus/Diptheria) or Tdap (Tetanus/Diptheria/Pertusis) _____

Pneumovax: pneumonia vaccine _____

Zostavax: Shingles vaccine _____

Influenza: flu shot _____

Patient Name: _____ **Date:** _____

Physician Signature: _____ **Date:** _____