sansum CLINIC

Name: _____

MRN: _____

DOB: _____

Annual Wellness Visit Questionnaire

Question	Response *(Fill in or check box.)*	Comment
1. How often do you have trouble handling stressful things such as your health, finances, or work relationships?	☐ 1 - Always ☐ 2 - Usually ☐ 3 - Sometimes ☐ 4 - Rarely ☐ 5 - Never	
2. How often do you get the social and emotional support you need?	☐ 1 - Always ☐ 2 - Usually ☐ 3 - Sometimes ☐ 4 - Rarely ☐ 5 - Never	
3. In general, how satisfied are you with your life?	☐ 1 - Very satisfied ☐ 2 - Satisfied ☐ 3 - Dissatisfied ☐ 4 - Very Dissatisfied	
4. Do you struggle to hear the TV or radio, or struggle to understand conversations?	☐ Yes ☐ No	
5. Do you need help with preparing meals, transportation, shopping, taking your medicine, or managing your finances?	☐ Yes ☐ No	
6. Do you need help eating, getting dressed, grooming, bathing or using the toilet?	☐ Yes ☐ No	
7. Do you have a working smoke alarm in your home?	☐ Yes ☐ No	
8. Does your home have loose rugs in the hallway?	☐ Yes ☐ No	
9. Does your home have poor lighting?	☐ Yes ☐ No	
10. Does your home have grab bars in the bathroom?	☐ Yes ☐ No	
11. Does your home have handrails on the stairs?	☐ Yes ☐ No	
12. Do you live alone?	☐ Yes ☐ No	
13. Do you always fasten your seat belt when you are in the car?	☐ Yes ☐ No	
14. In the past 7 days, on how many days did you drink alcohol?		
15. On how many of those days did you have four or more drinks?		

Question	Response *(Fill in or check box.)*	Comment
16. Do you ever drive after drinking or ride with a driver who has been drinking?	☐ Yes ☐ No	
17. How many days a week do you usually exercise?		
18. How intense is your typical exercise?	☐ 1 - Currently not exercising ☐ 2 - Light (*Example*: slow walking) ☐ 3 - Moderate (*Example*: brisk walking) ☐ 4 - Heavy (*Ex*: jogging or swimming) ☐ 5 - Very Heavy (*Ex*: running)	
19. On a typical day, how many servings of high fiber or whole grain foods do you eat? (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, ½ cup of cooked brown rice or whole wheat pasta)		
20. On a typical day, how many servings of fruits and/or vegetables do you eat? (1 serving=1 cup of fresh vegetables, 1/2 cup of cooked vegetables, or 1 medium piece of fruit.)		
21. On a typical day, how many servings of fried or high-fat foods do you eat? (ex: 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)		
22. In the past 7 days, on a scale of 1 – 10, how much pain have you felt? (1= none/minimal pain, 10 = the worst pain you can possibly imagine)		
23. How many hours of sleep do you usually get each night?		
24. Who are your current medical suppliers? (*Example*: durable medical equipment)		

_____ _____

Signature of Patient or Patient Representative Date Signed

_____ _____

Physician Signature Date Signed