

Health and Wellness Assessment

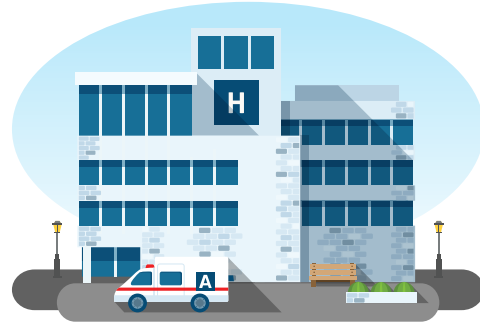
GENERAL WELLNESS

In general, would you say your health is?

- Excellent
- Good
- Fair
- Poor

In the past 12 months, have you stayed overnight as a patient in a hospital?

- None
- Once
- Two or three times
- Four or more times



In the last 12 months, how many times did you visit a physician or clinic?

- None
- Once
- Two or three times
- Four to six times
- Seven or more times

Do you feel you have adequate social/emotional support?

- Yes
- No

Do you experience a high stress level or difficulty coping?

- Yes
- No

LIFESTYLE

Do you usually eat a diet that has four servings of fruit and vegetables, includes whole grain and fiber and avoids other than occasional servings of high fat foods?

- Yes
- No

Do you usually exercise at least 30 minutes or more, four days a week?

- Yes
- No

In the past seven days, how much pain have you felt?

- None
- Some
- A lot



How would you describe the condition of your mouth and teeth (including false teeth or dentures)?

- Excellent
- Good
- Poor

In the past seven days, have you had any trouble falling or staying asleep?

- Yes No

In the past seven days, have you had problems with constipation?

- Yes No

Many people experience problems with urinary incontinence or the leakage of urine. In the past six months, have you been affected by the accidental leakage urine?

- Yes No

Do you have any problems with your hearing?

- Yes No

Do you or any of your family members have concerns about your memory?

- Yes No

In a typical week, how much alcohol do you drink?

- None
 Two drinks per day or less
 More than two drinks per day

Do you ever drive after drinking or ride with a driver who has been drinking?

- Yes No

Do you always fasten your seatbelt when you are in the car?

- Yes No



PERSONAL SAFETY

Do you know where to locate and properly use a first aid kit and fire extinguisher in case of emergency?

- Yes No

Do you wear sunscreen?

- Yes No

Does your home have rugs in the hallway?

- Yes No

Does your home have grab bars in the bathroom?

- Yes No

Does your home have handrails on the stairs?

- Yes No Does not apply

Does your home have good lighting?

- Yes No

Do you have smoke detectors in your home?

- Yes No



Do you have Carbon Monoxide detectors in your home?

- Yes No

Is the heat in your home adequate?

- Yes No

Do you feel safe at home?

- Yes No



INDEPENDENCE

In the past seven days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet?

- Yes No

In the past seven days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medications?

- Yes No

Have you fallen in the last year?

- Two or more falls in the last year or fall with injury in the last year
 No falls in the last year, or one fall with no injury in the last year

MENTAL HEALTH

Over the last two weeks, how often have you felt little interest or pleasure in doing things?

- Not at all
 Several days
 More than half of the days
 Nearly every day

Over the last two weeks, how often have you felt down, depressed or hopeless?

- Not at all
 Several days
 More than half of the days
 Nearly every day



PLANNING AHEAD

Please select all of the below that you have completed:

- Power of attorney
 Living will
 Advance directive

Please bring these documents with you to your appointment.

Please list the names of your doctors, medical providers, nurses and medical suppliers that you see outside of Utica Park Clinic.

NAME	SPECIALTY	SERVICES YOU RECEIVE

Please provide the date and location for the last time the following tests were performed.

TEST	DATE	LOCATION
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density		
Eye Exam		

Please provide the date and location for the last time the following immunizations were given.

IMMUNIZATION	DATE	LOCATION
Flu		
Pneumonia		
Shingles		