TORRANCE MEMORIAL PHYSICIAN NETWORK

WELLNESS HEALTH QUESTIONNAIRE AGE 65 Y/O AND OLDER

Name: _____ Today's Date: _____ Date of Birth:_____

Completed by if other than patient:_____ Relationship:_____

Please update any changes that have occurred in the last year

Allergies? ☐ Yes ☐ No Allergy: _____ Reaction:_____
Allergy: _____ Reaction:_____

Changes in Medications? ☐Yes ☐ No

(Please list all medications you are taking, including over-the-counter medications, vitamins, laxatives, and herbal supplements. Also include new medications prescribed since your last visit or changes in dosage)

Medication/Supplement:	Dose:	Taken How/How Often?	Who Prescribed This?

Are you having any problems filling your prescriptions due to their high cost of the medications? ☐Yes ☐ No

Name and Address of Preferred Pharmacy_____

Your Specialists (Please list those you currently see or have seen)

Name	Specialty	Name	Specialty

Are you suffering from pain? ☐Yes ☐ No

How would you rate your pain on a scale of 0 to 10, with 10 being the most severe pain? _____

If yes, what is the location of the pain? _____

Do you have someone designated to make health decisions on your behalf? (If you could not make decisions for yourself) ☐Yes ☐ No *(Please mark your answer below)*

☐ Advanced Directive is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.

☐ Living will is a written statement detailing a person's desires regarding their medical treatment in circumstances in which they are no longer able to express informed consent.

☐ POLST- Provider Orders for Life-Sustaining Treatment is a standardized, portable, single page medical order that documents a conversation between a provider and a patient with a serious illness or frailty towards the end of life.

☐ Other-Durable Power of Attorney(A document established by an individual grant another person the right and authority to handle matters related to their health care) or Healthcare Proxy (A document that allow a patient to appoint an agent to make healthcare decisions)

Is there a copy in your chart? ☐Yes ☐ No

Name: _____ Today's Date: _____ Date of Birth:_____

Past Medical and Surgical History:(Please list most recent first)

Surgery	Year	Hospitalization	Year

Immediate Family History:

(Please note the following diseases: Cancer, Diabetes, High Blood Pressure, Heart Trouble, Stroke, Seizures, Thyroid Disorder, Mental Disorders, Asthma, Osteoporosis, Tuberculosis)

Family:	Age (if living)	Deceased: (note age and cause)	Healthy or noted Illness(es):	Additional Siblings with age and condition:
Father:				
Mother:				
Brother:				
Sister:				
Son:				
Daughter:				

Social History

Tobacco Use: ☐ Never ☐ Former ☐ Current
# of Cig/Packs per Day: _____ # of Years Smoked:_____
Type of Tobacco use: _____
Age Started _____ If Former Age Quit_____

Alcohol Use: ☐ Never ☐ Former ☐ Current
Type:_____
#Drinks/Week_____

Illicit Drugs: ☐ Never ☐ Former ☐ Current
Type: _____

Employment: Are you currently Employed: ☐Yes ☐ No ☐ Retired

Occupation: _____ Hours worked per week: _____

Is your work satisfying and free from undue pressure or stresses? ☐Yes ☐ No

Do you miss much time from work? ☐Yes ☐ No

Education: (highest education obtained) _____

Exercise: Do you exercise regularly? ☐Yes ☐ No If yes, what type of exercise: _____
Number of days per week: _____
Hours per day: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
# of Previous Marriages: _____

How is your relationship with your spouse? _____ Is your sex life satisfying? ☐Yes ☐ No

Children:

How is your relationship with your children? _____ Number of Children: _____Girls _____ Boys

Nutrition: Are you on a specific diet? ☐Yes ☐ No If yes, which type of diet? _____

Caffeine Intake**:** ☐ Yes ☐ No
☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Chocolate Daily Intake: _____

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Health Risk Assessment

(Please mark your answer)

Are there hazards in your house that might hurt you?	☐ No	☐ Yes
Do you need someone to help you get up in the morning?	☐ No	☐ Yes
Have you fallen in the past year?	☐ No	☐ Yes
Are you worried you might fall?	☐ No	☐ Yes
Do you use a cane or walker?	☐ No	☐ Yes
In the past four weeks, have you fallen or felt dizzy when standing up?	☐ No	☐ Yes
How many times have you fallen in the past year?	#_____	

Functional Assessment

(Please mark your answer)

Independent/able to complete task without assistance	Require Assistance	Dependent on assistance	
☐	☐	☐	Bathing yourself
☐	☐	☐	Dressing yourself
☐	☐	☐	Toileting /grooming
☐	☐	☐	Go up stairs
☐	☐	☐	Transferring from Bed or Chair
☐	☐	☐	Feeding yourself
☐	☐	☐	Continence (Bowel or Urine)
Do you ever have trouble with Urine Incontinence? ☐ No ☐ Yes			Do you ever have trouble with Bowel Incontinence? ☐ No ☐ Yes

Home Safety Screening

(Please mark your answer)

☐ Yes ☐ No Do you wear a seat belt while in an automobile?
☐ Yes ☐ No Are working smoke alarm(s) available for use in your home?
☐ Yes ☐ No Do you have a carbon monoxide detector in your home?

Alcohol Screening Test

	Scoring System					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times per month	2 to 3 times per week	4 or more times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 to 2	3 to 4	5 to 6	7 to 9	10 or more	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

If you have a score of 5 or more on the Alcohol Screening Test further questions may be needed.

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PATIENT HEALTH QUESTIONAIRE (PHQ-9)

Circle to indicate your answer

Have you been diagnosed with Depression in the past 2 years?	**NO**	**YES**
Have you been on an antidepressant medication in the past 2 years?	**NO**	**YES**

Over the last 2 weeks have you often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
1)	Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2)	Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3)	Trouble falling or staying asleep or sleeping to much	**0**	**1**	**2**	**3**
4)	Feeling tired or having little energy	**0**	**1**	**2**	**3**
5)	Poor appetite or over eating	**0**	**1**	**2**	**3**
6)	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7)	Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8)	Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
9)	Thoughts that you would be better off dead, or of hurting yourself in some way	**0**	**1**	**2**	**3**
		Add columns:	+	+	
			(Add totals for the 3 columns)	**TOTAL**	

10 If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____