Bull City Family Medicine and Pediatrics
Wellness Checkup Questionnaire

Name: _____ Date: _____

Date of Birth: _____

Please complete this checklist before seeing your doctor or nurse.

Your responses will help you receive the best health care possible.

Thank you in advance for completing this form.

1. Compared with other people your age, how has your health been in the past 4 weeks?

   _____Excellent _____Very Good ____Good _____Fair _____Poor

2. Do you exercise for more than 20 minutes, three or more times a week?

   _____ Yes _____ No

   What type of exercise do you do:_____

3. To what extent do you find your health limiting your ability to do moderate activities, such as walking fast, gardening, carrying two bags of groceries at a time, or pushing a vacuum?

   _____Not at all _____A little bit ____Moderately

   _____Quite a bit _____All the time

4. Do you have trouble with any of the following: (check all that apply)

   _____ Bathing or showering _____ Getting dressed
   _____ Eating _____ driving

   _____ Sitting or getting up from a chair _____ Walking

   _____ Using the toilet _____ preparing meals or doing house chores

5. Has your pain limited your daily activities in the past 4 weeks?

   _____Not at all _____A little bit ____Moderately

   _____Quite a bit _____All the time

6. In the past 12 months have you fallen?

   _____Yes _____No

   If yes, how many times?_____

   Were you injured as a result of any of the falls?_____

   Do you have any problems with gait or balance?_____

7. Many people sometimes have trouble controlling when they void or urinate. This is called urinary incontinence. Do you feel like you have trouble with this?

   _____Yes_____No

8. During the past 4 weeks, were you able to get help when you wanted or needed it?

   *For example, if you felt lonely and needed someone to talk too, needed help with household chores or were sick and needed someone to take care of you.

   _____Yes, I have the help I need.

   _____Yes, I can usually get the help that I need.

   _____Yes, I can sometimes get the help that I need.

   _____No, there aren't people available to help me.

9. Over the past 2 weeks have you been bothered by any of the following problems? Little interest or pleasure in doing things?

   ___not at all ___several days ___More than half the days ___Nearly everyday

   Feeling down, Depressed or Hopeless?

   ___not at all ___several days ___More than half the days ___Nearly everyday

10. Are you interested in talking to someone about your feelings (such as sadness, anger, loneliness, worry or any other feeling that is bothering you)?
_____Yes _____No

11. Do you use tobacco products?
_____ cigarettes _____ cigars ____smokeless tobacco
_____ vape/electronic or e-cigarettes

12. How many drinks of wine (5oz), beer (12oz), or liquor (1oz) do you have per week?
_____10 or more drinks per week _____6-9 drinks per week
_____2-5 drinks per week _____1 drink per week or less
_____No alcohol at all

13. Do you use marijuana or other recreational drugs?
____ yes ____ no
if yes, describe what you use:

14. Do you have any financial difficulties preventing you from receiving:
(check all that apply)
_____Medical care _____Medications _____Eating healthy

15. How much do you wear your seat belt when driving or riding in a motor vehicle?
_____Not at all _____Some of the time ____All of the time

17. Do you have trouble with your hearing?
_____Not at all _____A little bit ____a lot

18. Do you have trouble with your vision?
_____Not at all _____A little bit ____a lot

19. Do you have any of the below problems? (check all that apply)

_____ teeth or dental problems _____ sexual problems

____falling or dizzy when standing

20. Do you receive routine dental care (dental exam and cleaning at least once a year)?

____ yes ____ no

21. Do you receive routine vision care (eye exam at least once every couple years)?

____yes ____ no

22. Do you have an Advanced Directive or Living Will for medical decisions?

" A **living will**, also called a directive to physicians or advance directive, is a document that lets people state their wishes for end-of-life medical care, in case they become unable to communicate their decisions. It has no power after death"

If yes who has a copy?

23. What "Over the Counter" pills (vitamins, dietary supplements , medications) do you take?

Please list below: