Paloma MEDICAL GROUP
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ADULT ANNUAL WELLNESS ASSESSMENT

Thank you for taking the time to complete this survey.

Name: _____ Appointment Date: _____

Date of Birth: _____/_____/_____Preferred Language: _____

Race/Ethnicity: ☐ American Indian ☐ Asian ☐ Hispanic ☐ African American ☐ Caucasian
☐ Native Hawaiian ☐ Pacific Islander ☐ Other _____

In general, how would you rate your health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Please list all providers and suppliers of your medical care such as primary care physicians, specialty physicians, chiropractors, pharmacies, herbalists and therapists.

Primary Care Physician(s)	**Specialty**
Other Patient Care Team members	**Specialty**

Family History: Please check the appropriate box of the conditions that apply to your blood relatives:

Relation	**Alive**	**Deceased**	Alcohol abuse	Arthritis	Asthma	Birth Defects	Cancer	Chronic Obstructive lung disease (COPD)	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Learning Disability	Mental illness	Mental Retardation	Miscarriages	Stroke	Vision loss
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Family history comments:

Surgical History:

Surgery	Yes	No	Place	Date
Appendectomy	☐	☐	_____	_____
Brain surgery	☐	☐	_____	_____
Breast Surgery	☐	☐	_____	_____
Gall Bladder Surgery	☐	☐	_____	_____
Colon surgery	☐	☐	_____	_____
Cosmetic surgery	☐	☐	_____	_____
C-Section	☐	☐	_____	_____
Eye surgery	☐	☐	_____	_____
Spine surgery	☐	☐	_____	_____
Hernia repair	☐	☐	_____	_____
Tubal Ligation	☐	☐	_____	_____
Heart Valve Replacement	☐	☐	_____	_____
Prostate surgery	☐	☐	_____	_____
Heart Bypass	☐	☐	_____	_____
Vasectomy	☐	☐	_____	_____

Other surgical history: _____

Do you have any of the following health problems

☐ Diabetes ☐ Kidney Problem ☐ Stroke ☐ Alzeimer's/Dementia
☐ Liver Problem ☐ COPD (Lung Disease) ☐ Heart Problems ☐ Low sexual desire
☐ Allergies ☐ Anemia ☐ Heart Attack ☐ Nerve Disease
☐ Anxiety ☐ Emphysema ☐ Osteoporosis ☐ Heartburn (GERD)
☐ Seizures ☐ Asthma ☐ Glaucoma ☐ HIV/AIDS
☐ High blood pressure ☐ Thyroid Disease ☐ Tuberculosis ☐ Ulcers
☐ Transplant (type) _____ Cancer (Type) _____
☐ Other Medical History: _____

In the <u>past 12 months,</u> how many times have you been a patient in a hospital where you stayed overnight?
☐ Not at all ☐ 1 time ☐ 2 times or more

Current Medications: Please include prescriptions, over-the counter medications, vitamins and supplements.

Medication name	Dose	Route	Frequency

Medication Allergies:

Medication	Reaction

Do you take daily aspirin? ☐ No ☐ Yes If "Yes" what is the reason? _____

☐

Over the past 2 weeks how often have you been bothered by:

Please circle one	Not at all	Several days	More than half the days	Nearly Every day
a. Little interest or pleasure in doing things	☐ **0**	☐ **1**	☐ **2**	☐ **3**
b. Feeling down, depressed or hopeless	☐ **0**	☐ **1**	☐ **2**	☐ **3**
c. Trouble falling or staying asleep, or sleeping too much	☐ **0**	☐ **1**	☐ **2**	☐ **3**
e. Feeling Tired or having little energy	☐ **0**	☐ **1**	☐ **2**	☐ **3**
f. Poor appetite or overeating	☐ **0**	☐ **1**	☐ **2**	☐ **3**
g. Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐ **0**	☐ **1**	☐ **2**	☐ **3**
h. Trouble concentrating on things, such as reading the newspaper or watching television	☐ **0**	☐ **1**	☐ **2**	☐ **3**
i. 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**
j. Thoughts that you would be better off dead or of hurting yourself in some way	☐ **0**	☐ **1**	☐ **2**	☐ **3**

Are you being treated for depression with medication ? ☐ No ☐ Yes

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Never

Have you ever smoked cigarettes, a pipe, cigars, or chewed tobacco? ☐ No ☐ Yes

a. If "Yes", are you currently smoking or using tobacco? ☐ No ☐ Yes

b. If "Yes". would you like assistance to stop using tobacco? ☐ No ☐ Yes

During the <u>past month</u>, how many drinks of wine, beer, or other alcoholic beverages did you have?

☐ None ☐ 1 drink per week ☐ 2-6 drinks per week ☐ 6-9 drinks per week ☐ 10 or more per week

Do you exercise or do moderate physical activity such as walking <u>5 days a week?</u> ☐ No ☐ Yes

How many of the following do you typically eat each day?

a. Fruits and vegetable _____ serving / day

b. High fiber or whole grain foods _____ serving / day

c. Fried or high- fat food _____ serving / day

d. Sugar-sweetened (not diet) beverages _____ serving / day

Do you always fasten your seat belt when you are in a car? ☐ No ☐ Yes

Do you have Advanced Directive, Living Will or a POLST? ☐ No ☐ Yes

Please record the last year you had the following. If you do not know, leave blank.

Hepatitis B Vaccine	_____	Tetanus Diphtheria vaccine	_____
Pneumonia vaccine (Pneumococcal 23)	_____	Zostavax (shingles)	_____
Pneumonia vaccine (Pneumococcal 13)	_____	Flu vaccine	_____
PSA Test	_____	Bone Density Scan	_____
Colonoscopy or FOBT (Fecal Occult Blood Test)	_____	Diabetes Self-Management	_____
Echocardiogram	_____	Eye Glaucoma Exam	_____
Glucose	_____	Hearing Exam	_____
Mammogram	_____	Nutritional Therapy	_____
Pap Smear	_____	Pelvic Exam	_____
Prostate Exam	_____	PSA Test	_____
Rectal Exam	_____	Smoking Cessation	_____

General

Do you eat a well-balanced diet? ☐ Yes ☐ No

Approx. weight now _____ 1 yr ago _____

Maximum weight _____

Exercise? Frequency/Wk _____

Activities _____

Any sexual concerns? ☐ Yes ☐ No

Year of Last Complete Physical _____

Headaches	☐ Yes	☐ No
Glasses/Contacts	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Eye disease or injury	☐ Yes	☐ No

Year Last Checked for Glaucoma _____

Itching eyes or nose/Hay Fever	☐ Yes	☐ No
Septal deviation/polyps	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No
Sinus trouble	☐ Yes	☐ No
Ear disease	☐ Yes	☐ No
Impaired hearing	☐ Yes	☐ No
Ringing in the ears	☐ Yes	☐ No
Hoarseness	☐ Yes	☐ No

NECK

Stiffness	☐ Yes	☐ No
Enlarged glands	☐ Yes	☐ No
Injury	☐ Yes	☐ No

RESPIRATORY

Coughing up blood	☐ Yes	☐ No
Chronic cough (including Smoker's Cough)	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

How many blocks can you walk without having to catch your breath? _____

Night sweats	☐ Yes	☐ No
Skin test for Tuberculosis	☐ Yes	☐ No
If yes, year tested & results _____	☐ Yes	☐ No
Year of last chest x-ray _____	☐ Yes	☐ No

CARDIOVASCULAR

Chest pain or Angina pectoris	☐ Yes	☐ No
Shortness of breath when lying flat	☐ Yes	☐ No
Pain in legs when walking, relieved at rest	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No
Ankles often badly swollen	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Rapid, hard or skipped heart beats	☐ Yes	☐ No

Year of last EKG _____

Have you had a stress treadmill? Year: _____ ☐ Yes ☐ No

GASTROINTESTINAL

Change in appetite	☐ Yes	☐ No
Heartburn or indigestion	☐ Yes	☐ No
Sour taste in throat or mouth	☐ Yes	☐ No
Intolerance to spicy foods, coffee or alcohol	☐ Yes	☐ No
Ever vomited blood?	☐ Yes	☐ No
Do foods stick in throat?	☐ Yes	☐ No
Gallbladder trouble/intolerance to greasy foods	☐ Yes	☐ No
Intolerance to milk products	☐ Yes	☐ No
Hiatal hernia	☐ Yes	☐ No
Pancreatis	☐ Yes	☐ No
Do you often vomit?	☐ Yes	☐ No
Crampy abdominal pain	☐ Yes	☐ No
Chronic constipation	☐ Yes	☐ No
Frequent diarrhea	☐ Yes	☐ No
Change in bowel habits	☐ Yes	☐ No
Bloody or black bowel movements	☐ Yes	☐ No
Hemorrhoids or piles	☐ Yes	☐ No

Did someone other than the patient help fill this out? ☐ Yes ☐ No

Completed by: _____

Relationship: _____

GENITORURINARY

Loss of urine when cough or sneeze	☐ Yes	☐ No
Kidney or bladder infection	☐ Yes	☐ No
Burning or frequent urination	☐ Yes	☐ No
Feeling must go immediately?	☐ Yes	☐ No
Do you have to get up at night to urinate? #	☐ Yes	☐ No
Blood in urine	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Swelling of hands and feet	☐ Yes	☐ No
Difficulty starting urination?	☐ Yes	☐ No
Decrease I strength of stream	☐ Yes	☐ No

MUSCULOSKELETAL

Significant arthritis/joint pain	☐ Yes	☐ No
Low back pain	☐ Yes	☐ No
Muscle weakness or tenderness	☐ Yes	☐ No
Difficulty walking	☐ Yes	☐ No

Fractures: _____

SKIN

Skin disorders: _____ ☐ Yes ☐ No

NEUROLOGIC / PSYCHIATRIC

Numbness/paralysis	☐ Yes	☐ No
Fainting spells	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Are you often depressed?	☐ Yes	☐ No
Are you often anxious or nervous?	☐ Yes	☐ No
Do you ever wish you were dead and away from it all?	☐ Yes	☐ No
Do you often worry?	☐ Yes	☐ No
Have you ever been under psychiatric care?	☐ Yes	☐ No

HEMATOLOGIC

Excessive bleeding or abnormal bruising ☐ Yes ☐ No

ENDOCRINE

Crave large amount of fluids	☐ Yes	☐ No
Intolerance to slightly warm rooms	☐ Yes	☐ No
Intolerance to slightly cool rooms	☐ Yes	☐ No
Change in textures of hair or skin	☐ Yes	☐ No
Change in voice (as an adult)	☐ Yes	☐ No
Hair loss	☐ Yes	☐ No
Diminished sex drive	☐ Yes	☐ No
Darkening of skin	☐ Yes	☐ No

GYNECOLOGICAL(This section for women only)

Age when periods started _____years old

Frequency: every _____ days; Last period: _____

Are they abnormal or irregular? ☐ Yes ☐ No

Menopausal : Age _____

Number of pregnancies: _____ C/sections: _____

Term deliveries: _____ Premature: _____

Miscarriages: _____ Abortions: _____

Pelvic inflammatory disease	☐ Yes	☐ No
Pain with intercourse	☐ Yes	☐ No
Date of last cancer smear _____Normal?	☐ Yes	☐ No
Breast masses, lumps, cyst	☐ Yes	☐ No
Nipple discharge	☐ Yes	☐ No
Skin discoloration/dimpling	☐ Yes	☐ No
Family history of breast cancer	☐ Yes	☐ No

Date of last mammogram _____