utica park clinic

Health & Wellness Assessment

Name ____ Date of Birth _________________

List the names of any doctors, medical providers, nurses, or medical suppliers that you have:

Name	Phone	Services You Receive

General Health

In general, would you say your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

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

- ☐ Not at all
- ☐ 1 time
- ☐ 2 or 3 times
- ☐ 4 or more times

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

- ☐ Not at all
- ☐ 1 time
- ☐ 2 or 3 times
- ☐ 4 to 6 times
- ☐ 7 or more times

Have you ever been told by a doctor or a health professional that you have diabetes or high blood sugar?

- ☐ Yes
- ☐ No

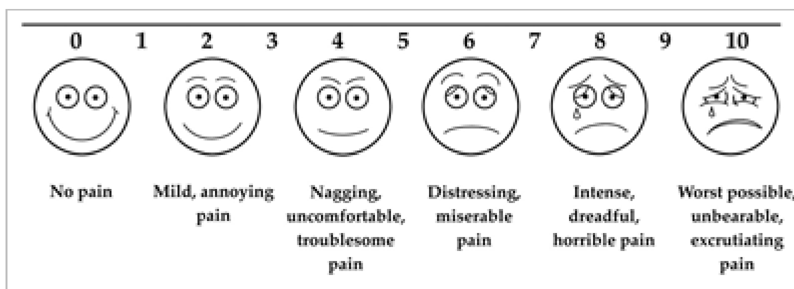
<u>Pain</u>

Do you have pain?

- ☐ Yes
- ☐ No

If you have pain, where is it located? _______________

If you have pain, how bad is the pain on a scale of 1 to 10, ten being the worst pain you can imagine?



Circle a number below.

<u>Sleep</u>

How many hours of sleep do you usually get each night?

- ☐ Less than 1 hour
- ☐ 1-3 hours
- ☐ 4-6 hours
- ☐ 7-8 hours
- ☐ More than 8 hours

<u>Prevention/Screening Tests</u>

Have you discussed taking a daily aspirin with your doctor?

- ☐ Yes
- ☐ No

When was your last colonoscopy? _______________

When was your last bone density test (DXA Scan)? _______________

When was your last eye exam? _______________

When was your last flu shot? _______________

When was your last pneumonia shot? _______________

When was your last shingles shot? _______________

Have you had an HIV test in the past 12 months?

- ☐ Yes, and the test was positive.
- ☐ Yes, and the test was negative.
- ☐ No, but I would like to have one.
- ☐ No, but I prefer not to have one.

Men Only: Have you had a prostate exam in the last 12 months?

- ☐ Yes
- ☐ No

Women Only: Have you had a mammogram in the last 12 months?

- ☐ Yes
- ☐ No

Women Only: Have you had a pap test in the past 3 years?

- ☐ Yes
- ☐ No

Mental and Emotional Health

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

- ☐ Almost all of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost never

Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?

- ☐ Almost all of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost never

Bladder Health

Many people experience problems with urinary incontinence, the leakage of urine. In the past 6 months, have you accidentally leaked urine?

- ☐ Yes
- ☐ No

How much of a bother, if any, was the urine leakage for you? *Circle a number below.*

I'm not bothered at all					I'm bothered a great deal
0	1	2	3	4	5

Hearing/Vision/Memory

Do you have any hearing problems?

- ☐ Yes
- ☐ No

If you have hearing problems, do you wear hearing aids?

- ☐ Yes
- ☐ No

Do you have any vision problems?

- ☐ Yes
- ☐ No

Do you have any memory problems?

- ☐ Yes
- ☐ No

Advanced Directives

Do you have a "Power of Attorney"?

- ☐ Yes, who is it? _________________. How are they related to you? _________________.
- ☐ No

Do you have a "Living Will" or Advanced Directive for Health Care?

- ☐ Yes
- ☐ No

If you DO NOT have a "Living Will" or Advanced Directive, would you like help completing one?

- ☐ Yes
- ☐ No

Dental/Oral Health

Do you have problems with your teeth or with chewing?

- ☐ Yes
- ☐ No

Have you seen a dentist within the last 12 months?

- ☐ Yes, and the date was __________.
- ☐ Yes, but I don't know the date.
- ☐ No

Personal Safety

Is there a friend, relative, or neighbor who would take care of you for a few days, if necessary?

- ☐ Yes
- ☐ No

Place a mark by any of the following items that you need help with:

- ☐ Dressing
- ☐ Eating
- ☐ Using the bathroom
- ☐ Grooming
- ☐ Walking
- ☐ Bathing
- ☐ Using the phone
- ☐ Preparing meals
- ☐ Housework
- ☐ Laundry
- ☐ Taking medications
- ☐ Shopping
- ☐ Managing money
- ☐ Transportation

Do you have any of the following in your home?

- ☐ Rugs in the hallway
- ☐ Pets
- ☐ Poor lighting
- ☐ Electric cords in the walking pathway

Do you have grab bars in the bathroom?

- ☐ Yes
- ☐ No

Do you have stairs <u>without</u> handrails?

- ☐ Yes
- ☐ No

Have you had a fall at home or while away from home in the last year?

- ☐ Yes
- ☐ No

If you have fallen, how many times did you fall in the last year? ________________

<u>Seat Belt Use</u>
Do you always fasten your seat belt when you are in the car?

- ☐ Yes
- ☐ No

<u>Exercise</u>
How many days a week do you usually exercise?

______ day(s) per week

On days when you exercise, for how long do you usually exercise (in minutes):

______ minute(s) per day

How intense is your typical exercise?

- ☐ Light (like stretching or slow walking)
- ☐ Moderate (like brisk walking)
- ☐ Heavy (like jogging or swimming)
- ☐ Very heavy (like fast running or stair climbing)
- ☐ I am currently not exercising

<u>Nutrition</u>
On a typical day, how many servings of fruits and/or vegetables do you eat?

(1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)

______ serving(s) per day

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, or ½ cup of cooked brown rice or whole wheat pasta.)

______ serving(s) per day

On a typical day, how many servings of fried or high-fat foods do you eat?

(Examples include 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.)

______ serving(s) per day

Tobacco Use

Do you currently smoke cigarettes or use other types of tobacco?

- ☐ Yes
- ☐ No

Are you a former smoker?

- ☐ Yes, and I quit
- ☐ No, I've never smoked

If you quit smoking, how long ago did you quit smoking cigarettes?

- ☐ Less than 6 months ago
- ☐ 6–11 months ago
- ☐ 1–5 years ago
- ☐ 6–10 years ago
- ☐ More than 10 years ago

Indicate below if you currently use any of these other tobacco products:

- ☐ Cigars
- ☐ Pipes
- ☐ Chewing tobacco/snuff
- ☐ I use no other tobacco products

Alcohol Use

In a typical week, how many days do you drink alcohol?

______ day(s) per week

On days when you drink alcohol, how many alcoholic drinks do you consume?

______ drink(s) per day

In a typical week, how often do you have 5 or more alcoholic drinks on one occasion?

- ☐ Never
- ☐ Once a week
- ☐ 2–3 times per week
- ☐ More than 3 times per week

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

- ☐ Yes
- ☐ No

____

Patient Signature Date Completed

____

Reviewer's Initials/Date