GRAND MEDICAL ASSOCIATES

Wellness

Please take a few minutes to fill out this information so we may expedite the question portion and give complete attention to your wellness exam.

Personal Information

First Name _____ Last Name _____ Gender _____ DOB _____

Address _____ City _____ State _____ Zip _____

General Patient Information

In general, how would you rate your overall health?

☐Poor ☐Fair ☐Good ☐Very Good ☐Excellent

In the past 7 days, have you needed help from others to eat, dress, bathe, use the toilet, or do laundry?

☐Yes ☐No

Do you exercise or do moderate physical activity such as walking for at least ½ hour a day?

☐Yes ☐No

On a scale from 0 to 10 where 0 is none and 10 is the highest, what is your pain level today?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Where is the pain? _____

Living Will - Do you have a living will? ☐Yes ☐No

Do we have a copy of your living will on file? ☐Yes ☐No If no, please bring a copy so we can scan it into your record.

Decision Maker - Can we record the name & contact information of your Decision Maker in your record?

Name: _____ Relationship: _____ Phone Number: _____

Hearing – Do you use hearing aide?

☐Yes ☐No

Colon – When and where was your last colonoscopy?

Month _____ Year _____ Location _____

What were the results? ☐Normal ☐Polyps ☐Unknown

When is your next colon screening due?_____ **OR** ☐ Check box if no repeat is required.

Mammo – When and where was your last mammogram? Was it ☐ Normal OR ☐ Abnormal?

Month _____ Year _____ Location _____

DEXA – When and where was your last bone density/DEXA scan? Results?_____

Month _____ Year _____ Location _____

Eye – When and where was your last eye exam?

Month _____ Year _____ Location _____

Foot – When and where was your last foot exam?

Month _____ Year _____ Location _____

Incontinence – Do you have urinary incontinence? ☐Yes ☐No

Falls – Have you had any falls within the past year? ☐Yes ☐No

If you fell, how many times? _____ Did you injure yourself? _____

Immunizations – When and where was your last immunization received?

Flu vaccine:

Month _____ Year _____ Location _____

Pneumonia 23:

Month _____ Year _____ Location _____

Immunizations (cont.) – When and where was your last immunization received?

Prevnar 13:
Month _____ Year _____ Location _____

Zostavax:
Month _____ Year _____ Location _____

Shingrix Part 1:
Month _____ Year _____ Location _____

Shingrix Part 2:
Month _____ Year _____ Location _____

Covid-19 Vaccine Part 1:
Month_____ Year_____ Location_____

Covid-19 Vaccine Part 2:
Month_____ Year_____ Location_____

Alcohol – Did you have a drink containing alcohol in the past year?

☐No ☐Yes If yes, how often did you have a drink and how many drinks do you typically have when drinking? _____

How often did you have 6 or more drinks on one occasion? _____

Nicotine – Do you use nicotine products?

☐No, I have never used nicotine

☐Former nicotine user. When did you quit? _____

☐Yes, I am a current nicotine user. ☐smoke ☐chew ☐vape ☐patch

How often do you use nicotine and how much?_____When did you start?_____

CBD/THC – Do you use CBD or THC products?

☐No, I have never used CBD/THC

☐Former CBD/THC user. When did you quit? _____

☐Yes, I am a current CBD/THC user. ☐smoke ☐vape ☐topical ☐oral

How often do you use CBD/THC and how much?_____When did you start?_____

Depression Screening:

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

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

Thank you for taking the time to fill out this information. It is greatly appreciated.

Signature _____

Date _____