Forum Family Medicine Wellness Review

Name_____ **Age**____ **Date:**_____

Exercise

In the past 7 days, how many days did you exercise? _____ days _____ minutes/day

How intense? ☐Light (stretch, slow walk) ☐Moderate (brisk walk) ☐Heavy (jogging/swimming)

☐Very heavy (fast running, stair climbing) ☐Weight lifting

Any obstacles to exercising?_____

Nutrition In the past 7 days, how many servings of each of the following did you typically eat each day?

Fruits and vegetables = ____ servings/day

(1 serving = 1 cup of fresh veggies, 1/2 cup cooked veggies, 1 medium piece of fruit)

High fiber or whole grain foods = ____ servings/day

(1 serving = 1 slice 100% whole wheat bread, 1 cup high fiber cereal, 1/2 cup of cooked cereal/ oatmeal, 1/2 cup of brown rice or whole wheat pasta)

Fried or high-fat foods = _____ servings/day

(fried chicken, fried fish, bacon, French fries, chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese or mayo)

Sugar sweetened (not diet) beverages (soda, sweet tea, juice) **= _____ servings/day**

Tobacco

In the last 30 days, have you used tobacco?

Smoked: ☐Yes ☐No Smokeless: ☐Yes ☐No

If yes to either, are you interested in quitting tobacco use within the next month?

☐Yes ☐No

Alcohol/ Marijuana

In the past 7 days, on how many days did you drink alcohol?

_____ days _____ drinks each time

On the days when you drank, how often do you have 5 or more drinks (4 for women) at one time?

☐Never ☐once in the week ☐2-3 times during the week ☐More than 3 times

In the past month, have you used marijuana? : ☐No ☐Yes —> ☐recreational ☐medical

Safety

Do you wear your seatbelt?	☐ never	☐ sometimes	☐ always
Do you wear a helmet for bicycle/motorcycle riding?	☐never	☐sometimes	☐always
If you have guns, do you keep them locked up?	☐Never	☐sometimes	☐always
Is there a smoke alarm in your home that works?	☐Yes	☐No	
Have you been a victim of violence in your family?	☐No	☐Yes	
Have you fallen in the past year?	☐No	☐Yes	

Emotional / relational In the past 2 weeks, how often have you

	most of the time			almost never
Felt down, depressed or hopeless?	☐	☐	☐	☐
Felt little interest or pleasure in doing things?	☐	☐	☐	☐
Had your feelings interfere in getting along with family or friends?	☐	☐	☐	☐
Felt nervous, anxious, or on edge?	☐	☐	☐	☐
Not been able to stop worrying or control your worrying?	☐	☐	☐	☐
Had trouble dealing with stress?	☐	☐	☐	☐
Gotten the social and emotional support you need?	☐	☐	☐	☐

Physical health

In the past 2 weeks, how often have you…	almost all the time			almost never
Had adequate amount and quality of sleep?	☐	☐	☐	☐
Felt sleepy during the daytime?	☐	☐	☐	☐
Suffered pain?	☐	☐	☐	☐
Been able to physically do what you want?	☐	☐	☐	☐

Sexual health

Are you sexually active?: ☐never ☐ currently ☐In past

Sexual preference: ☐men ☐women

Any risk factors for HIV/AIDS?

☐IV drug use ☐homosexual ☐>1 sexual partner since 1986

Do you use birth control?

☐No ☐Not applicable (vasectomy, hysterectomy, menopause, tubal) ☐Need info on this

☐Yes —> ☐condoms ☐birth control pill ☐implant ☐IUD ☐Injection

Preventive exams

Last dentist visit: _____ Last eye exam: _____

If over 50, have you had screening for colon cancer?

☐no ☐yes (when) _____

For Women: Last mammogram (if 40 or over)? _____

Last PAP test? _____ Any abnormal? ☐no ☐es

Immunizations: (year)

Tetanus/pertussis _____ Pneumonia _____ Shingles _____

Do you have a **Living Will or Advanced Directives** (in case of serious illness):

☐No ☐I would like info on this ☐Yes—> _____

Health Concerns/Problems to discuss (not included in wellness visit)

(additional schedule time required, co-pay/deductible applies)