Scott D Beede MD PA

Wellness Screening

Patient name *(last, first MI)*:	Today's date: / /
	Date of birth: / /

Marital status*(circle)*: Single Significant other Married Widowed Separated Divorced
Other *(specify)*:

Occupation (former occupation if retired): Retired: Yes No

Living conditions *(circle)*: Independent In-home assistance Assisted living Skilled nursing facility

Have you ever used tobacco *(circle)*: Yes No (if no go to next section)
Have you used tobacco in the last year *(circle)*: Yes No (if no, quit date _________________)
Type of tobacco *(circle)*: Cigarettes Cigars Chewing-tobacco Other: ____________________
Average daily amount:
Health problems related to tobacco use*(circle)*: No Yes *(indicate type of problem)*:

Have you ever used caffeine *(circle)*: Yes No (if no go to next section)
Have you used caffeine in the last year *(circle)*: Yes No (if no, quit date _________________)
Type of caffeine *(circle)*: Coffee, tea, soda, energy drinks Other: ____________________
Average daily amount:
Health problems related to caffeine use*(circle)*: No Yes *(indicate type of problem)*:

Have you ever used recreational drugs *(circle)*: Yes No (if no go to next section)
Have you used recreational drugs in the last year *(circle)*: Yes No (if no, quit date _________________)
Type of recreational drug(s): ____________________
Health problems related to recreational drug use*(circle)*: No Yes *(indicate type of problem)*:

Do you exercise regularly? yes no Type: Frequency:

Assistive devices and services *(hearing aids, dentures, canes, walkers, wheel chairs, home oxygen, home nursing, health aide etc.)*:

Advanced directives:
Do you have a living will? Yes No
Do you have a durable power of attorney for healthcare (healthcare surrogate)? Yes No
Have you previously established a "Do Not Resuscitate" order? Yes No

Activities of daily living:
I am fully independent: Yes No (if yes skip to next section)
I need full help with all daily activities: Yes No (if no, indicate activities below)
I need help with (circle all that apply): Dressing Grooming Shopping Bathing
Housework Feeding Toilet use Preparing meals

Fall risk: I have had 2 or more falls in the last year. Yes No
I have had any fall with injury in the last year. Yes No

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Review of Systems	Today's date:
Patient name *(last, first MI)*:	Date of birth:

Do you now or have you recently experienced any of the following problems *(circle yes or no)*:

Constitutional symptoms

Unexplained weight change	Y	N
Difficulty sleeping	Y	N
Loss of appetite	Y	N
Fatigue	Y	N
Fever or chills	Y	N
Drenching night sweats	Y	N

Eyes

Change in vision	Y	N
Sensitivity to light	Y	N
Double vision	Y	N
Eye pain	Y	N
Discharge or drainage	Y	N

Ears/Nose/Throat/Mouth

Change in hearing	Y	N
Ringing in ears	Y	N
Ear pain or drainage	Y	N
Nasal congestion	Y	N
Nose bleeds	Y	N
Snoring	Y	N
Change in voice or hoarseness	Y	N
Dry mouth	Y	N
Mouth sores or ulcers	Y	N
Sore throat	Y	N

Cardiovascular

Exertional chest pain/pressure	Y	N
Calf pain with walking	Y	N
Sudden loss of consciousness	Y	N
Dizziness	Y	N
Rapid or irregular heartbeat	Y	N
Shortness of breath lying down	Y	N
Lower extremity edema	Y	N
Foot wounds or ulcers	Y	N

Respiratory

Shortness of breath	Y	N
Cough	Y	N
Wheezing	Y	N
Coughing up blood	Y	N

Gastrointestinal

Difficulty or pain swallowing	Y	N
Nausea or vomiting	Y	N
Vomiting blood	Y	N
Heart burn or acid reflux	Y	N
Abdominal pain	Y	N
Change in bowel habits	Y	N
Diarrhea	Y	N
Constipation	Y	N
Bloody, black, or tarry stools	Y	N

Genitourinary

Urinary frequency or urgency	Y	N
Burning or painful urination	Y	N
Weak stream or hesitancy	Y	N
Blood in urine	Y	N
Urinating at night	Y	N
Unable to fully empty bladder	Y	N
Urinary incontinence	Y	N
Erectile dysfunction (ED)	Y	N
Painful intercourse	Y	N
Discharge	Y	N
Menstrual irregularities	Y	N

Endocrine

Cold or heat intolerance	Y	N
Change in body hair	Y	N
Excessive thirst	Y	N
Excessive volume of urine	Y	N

Musculoskeletal

Joint pain/swelling/stiffness	Y	N
Loss of range of motion	Y	N
Decreased muscle strength	Y	N
Painful walking	Y	N
Muscle cramps	Y	N

Skin/Breast

Rashes	Y	N
Itching	Y	N
Change in size, shape, or color of a skin lesion	Y	N
Non-healing sore	Y	N
Nail or skin loss or change	Y	N
Breast lump or discharge	Y	N
Pain in breast	Y	N

Neurological

Weakness in an extremity	Y	N
Numbness, burning, or tingling in an extremity	Y	N
Loss of balance	Y	N
Tremor	Y	N
Headache	Y	N
Memory loss	Y	N

Psychiatry

Depression	Y	N
Anxiety	Y	N
Irritability	Y	N
Changes in sex drive	Y	N
Problematic alcohol or drug use	Y	N

Hematology/Lymphatic

Abnormal bleeding or bruising	Y	N
Blood clots	Y	N
New growths, bumps, or masses	Y	N

Allergy/Immune

Environmental allergies	Y	N
Food allergies	Y	N
Recurrent infections	Y	N
Hives	Y	N

Alcohol Use Screening

1. How often do you have a drink containing alcohol?

Points		Score
0	Never (skip to question 9 and 10)	
1	Monthly or less	
2	2 to 4 times a month	
3	2 to 3 times a week	
4	4 or more times a week	

2. How many drinks (1.5 oz. of liquor, 5 oz. of wine, or 12 oz. of beer) do you have on a typical day when you are drinking?

Points		Score
0	1 or 2	
1	3 or 4	
2	5 or 6	
3	7, 8, or 9	
4	10 or more	

3. How often do you have five or more drinks on one occasion?

Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

4. How often during the last year have you found that you were not able to stop drinking once you started?

Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

5. How often during the last year have you failed to do what was expected of you because of drinking?

Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

6. How often during the last year have you needed to have a first drink in the morning to get yourself going after a heavy drinking session?

Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Points		Score
0	Never	
1	Less than monthly	
2	Monthly	
3	Weekly	
4	Daily or almost daily	

9. Have you or someone else been injured as a result of your drinking

Points		Score
0	No	
2	Yes, but not in the last year	
4	Yes, during the last year	

10. Has a relative or a friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

Points		Score
0	No	
2	Yes, but not in the last year	
4	Yes, during the last year	
	Total Score:	

Patient Health Questionaire – 9

Depression screening tool.

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully and indicate your response.

	Not at all	Several days	More than half of days	Nearly every day
Little interest or pleasure in doing things.				
Feeling down, depressed or hopeless.				
Trouble falling asleep, staying asleep, or sleeping too much.				
Feeling tired or having little energy.				
Poor appetite or overeating.				
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down.				
Trouble concentrating on things such as reading the newspaper or watching television.				
Moving or Speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual.				
Thinking that you would be better off dead or that you want to hurt yourself in some way.				