Patient Name_____**DOB**_____**Date**_____

WELLNESS QUESTIONAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems (circle your number)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
If you checked off any problems how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not very difficult ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

1. Do you have fatigue? How often does it affect your normal activities? (Check one)
   never rare sometimes often always
2. How often is stress a problem for you? (Check one)
   never rare sometimes often always
3. How do you handle the stress in your life? (Check one)
   never rare sometimes often always
4. How often do you get the social support/emotional support you need? (Check one)
   never rare sometimes often always
5. Do you have a support system of people who help you when you need it? Y N
6. Do you currently live with anyone at home? Do you feel safe at home? Y N
7. Are you being physically or emotionally harmed? Y N
8. Do you have a living will? If not, please ask for more information Y N
9. Do you use an assistive listening device? (Hearing aid) Y N
10. Do you have urinary incontinence? Y N
11. Do you use a cane, walker or power chair? Y N
12. When was your last dexascan and where? _____
13. When was your last mammogram and where?_____
14. If under 65 when was your last pap? Was is it normal?_____
15. When was your last colonoscopy and where? Stool occult card done?_____
16. When was your last eye exam? Do you wear glasses or contacts?_____
17. If you have asthma/copd , when was your last spirometry test? Where? _____
18. List any other doctors seen within the last year & any new surgeries since your last wellness
    _____
19. Have you received the following vaccines? When and where?

    Flu shot_____ Pneumonia_____ Shingles_____