

Health and Wellness Screen

Date of Screening _____

DIRECT MEASURES

Name _____ Age _____ Gender _____
 Height _____ Weight _____ BMI _____
 Blood Pressure _____ Lipid Screen Date _____
 Obtained Medication List Yes No
 Who is prescribing psychotropic medication? _____

DIABETES

Diabetes Yes No
 A1c within the past year Yes No A1c within the past 6 months Yes No
 Dilated eye exam within past year Yes No Foot exam within the past year Yes No

CONSUMER SELF REPORT

1. Have you ever been told by your doctor or other health professional that you have? (Check all that apply)
 - Angina or coronary heart disease
 - Heart attack or myocardial infarction
 - Stroke High blood cholesterol
 - High blood pressure or hypertension
2. Do you now smoke cigarettes? (Please check one)
 - Every day Some days Not at all
3. During the past month, did you participate in any physical activities or exercises such as running, aerobics, basketball or other sports, gardening or walking for exercise? Yes No
4. On the days when you drink alcohol, about how many drinks do you drink on average? (One drink is one can or bottle of beer or wine cooler, one glass of wine, one cocktail or one shot of liquor.)
 Average number of drinks per day _____
5. How would you describe the condition of your teeth: (Please check one)
 - Excellent Very good Good
 - Fair Poor
6. How long has it been since you had your teeth cleaned by a dentist or dental hygienist?
 Number of months _____
 Number of years _____
7. How would you say your general health is? (Please check one)
 - Excellent Very good Good
 - Fair Poor
8. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
 Number of days _____
9. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?
 Number of days _____
10. During the past 30 days, about how many days did poor physical or mental health keep you from doing usual activities, such as self-care, school, or recreation?
 Number of days _____

USUAL SOURCES OF CARE

Who is your primary care provider? _____
 How often in the past 12 months have you seen your primary care provider? _____
 How many times have you visited the Emergency Room in the last 12 months? _____