Beth Hanrahan, MD, L.L.C.

Annual Wellness Questionnaire

Patient: _____ DOB: _____

(Please Circle)

1. Do you need help with preparing meals, transportation, shopping, taking medicine, managing your finances or other activities of daily living? Yes No
2. Do you live alone? Yes No
3. Does your home have throw rugs? Yes No
4. Does your home have poor lighting or a slippery tub and shower? Yes No
5. Does your home have grab bars in bathrooms, handrails on stairs and steps? Yes No
6. Does your home have functioning smoke alarms? Yes No
7. When was your last glaucoma screening? _____
8. When was your last:
   - Pneumonia vaccine _____
   - Tetanus vaccine _____
   - Flu vaccine _____
   - Hepatitis B _____
9. Have you had the Shingles vaccine? Yes No
10. When was your last Bone Density test? _____
11. When was your last Colonoscopy? _____

12. Do you have an Advance Directive (aka living Will)? Yes No

13. Do you want information on Advance Directives? Yes No

14. During the past month, have you been feeling down, depressed, or hopeless? Yes No

15. During the past month have you often had little interest or pleasure in doing things? Yes No

16. Have you fallen in the last year? Yes No

17. Do you have any complaints of balance problems or difficulty walking? Yes No

18. Do you have trouble hearing the television or radio when others do not? Yes No

19. Do you have to strain or struggle to hear/understand conversations? Yes No

20. When was your last Mammogram? _____

21. What other doctors have you seen in the last year? (Name and Specialty) include Dentists and Eye Doctors.

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22. If you use other medical suppliers, please list those below: (i.e. Oxygen, CPAP, Home Health, etc.)

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_____

_____

Patient Signature: _____ Date: _____

Print Name: _____