

ANNUAL HEALTH HABITS QUESTIONNAIRE

Alcohol: Do you ever drink alcohol? No Yes
 Daily 1-2 per week 3-5 per week 1-2 per month 1-2 per year
 Have you ever felt like you should cut down on drinking? Yes No
 Have people ever criticized you for drinking? Yes No
 Do you ever feel bad or guilty about drinking? Yes No
 Have you ever taken a drink first thing in the morning to ease your nerves or cure a hangover? Yes No

Tobacco: Never a smoker/Smokeless Tobacco/Electronic Cigarette/Vaping
 Current every day smoker/Smokeless Tobacco/Electronic Cigarette/Vaping
 Current some days smoker/Smokeless Tobacco/Electronic Cigarette/Vaping
 Former Smoker/Smokeless Tobacco/Electronic Cigarette/Vaping Year quit _____ Years smoked _____

Substance Abuse: Do you use recreational/street drugs? Currently Use Previously used Never used

Employment: Employed Full Time Employed Part Time Retired Student Unemployed

Marital Status: Single Married Divorced Widowed Separated Number of Children _____

Type of Diet: Regular Diabetic Low Fat Low Carb Low Salt Low Calorie Vegetarian
 Other: _____

Caffeine Intake: None
 Coffee _____ cups per day Tea _____ cups per day Cola _____ cans per day

Exercise: Daily 1-2 times/week _____ mins 3-4 times/week _____ mins 5-6 times/week _____ mins

Are you Currently Sexually Active? Yes No
 If yes: are you trying for pregnancy? Yes No Contraceptive method used: _____
 Last Menstrual Cycle _____

Mental Health:

In the past TWO WEEKS have you felt down, depressed or hopeless?
 Not at all Several days Half the days Nearly Everyday
 In the past TWO WEEKS have you felt little interest or pleasure in your daily activities?
 Not at all Several days Half the days Nearly Everyday

Do you have an Advanced Directive, Living Will or Power of Attorney? _____
 Have you had a pneumonia shot? Yes No Date received/where: _____
 Do you get a yearly flu shot? Yes No Date received/where: _____
 Do you live alone? Yes No
 Have you fallen in the last 3 months? Yes No

Wellness Screenings:

Pap Smear (where/date) _____ Mammogram (where/date) _____
 Colorectal Screening (Colonoscopy/Fecal Occult Blood Test) where/date _____

Diabetes: Last A1C/Result _____ Last Eye Exam/Where _____ Endocrinologist _____

Covid-19 Vaccine: YES/NO Date? _____ Manufacturer? (circle) PFIZER MODERNA Johnson & Johnson

PATIENT NAME _____ DOB _____ DATE _____