Vatica Health WELL 365 PLUS
THE FUTURE OF HEALTHCARE

**Patient Name:** _____

**Date of Birth:** _____

# PATIENT QUESTIONNAIRE

Please fully complete this questionnaire as accurately as possible. This will be reviewed by your provider as part of your Annual Wellness Visit. Your health insurance plan is providing you an enhanced Annual Wellness Visit using Vatica Health, Inc. technology and clinical services. This questionnaire is Protected Health Information (PHI) safeguarded under HIPAA legislation.

## Social History

### Smoking History

What is your history of smoking cigarettes?

☐ Never Smoked

☐ Current Smoker

☐ Yes ☐ No Smoking and tobacco use cessation counseling session within the last year?

How many pack years have you smoked? (packs per day x number of years smoked)

☐ Less than 30 pack years

☐ Greater than 30 pack years

☐ Former Smoker

How many pack years did you smoke? (packs per day x number of years smoked)

☐ Less than 30 pack years

☐ Greater than 30 pack years

If you smoked greater than 30 pack years, when did you stop smoking?

☐ Stopped smoking greater than 15 years ago

☐ Stopped smoking less than 15 years ago

### Drug History

☐ No History of Illicit Substance Use (Prescription and/or Street Drugs)

☐ Illicit Substance Use, Current or Past Use (Prescription and/or Street Drugs)

*If you are using an Illicit Substance(s), select substance(s)*

☐ Cocaine

☐ Opioid

☐ Cannabis

☐ Sedative, Hypnotic or Anxiolytic

☐ Other Stimulant

☐ Hallucinogens

☐ Inhalants

☐ Other Psychoactive Substances

### Alcohol History

**Alcohol Use Status:**

☐ No Current Use

☐ Past Use

☐ Current or Past Use that meets the following criteria:

☐ Yes ☐ No Females of any age and Males above age 65: Do you drink more than 7 drinks per week or more than 3 drinks per occasion?

☐ Yes ☐ No Males aged 65 and below: Do you drink more than 14 drinks per week or more than 4 drinks per occasion?

*If Current or Past alcohol use, please complete the following:*

**Alcohol Misuse Screen / C.A.G.E. Assessment**

**C:** ☐ Yes ☐ No Have you ever felt you should cut down on your drinking?

**A:** ☐ Yes ☐ No Have people annoyed you by criticizing your drinking?

**G:** ☐ Yes ☐ No Have you ever felt bad or guilty about your drinking?

**E:** ☐ Yes ☐ No Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

## Self-Assessment

In the past 7 days, how many days did you exercise?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

☐ Yes ☐ No ☐ Unknown Have you been to the dentist in last 12 months?

### Depression Assessment

☐ Yes ☐ No Over the past 2 weeks, have you felt down, depressed, or hopeless?

☐ Yes ☐ No Over the past 2 weeks, have you felt little interest or pleasure in doing things?

## Fall Risk / Home Safety

### General

☐ Yes ☐ No Do you have any problems with your hearing?

☐ Yes ☐ No Do you have a problem with balance?

☐ Yes ☐ No Do you have a problem walking?

☐ Yes ☐ No A fall is when your body goes to the ground without being pushed.
Have you fallen in the past 12 months?
*If Yes to Fall:*

☐ Yes ☐ No Were you injured from the fall?

☐ Yes ☐ No Have you had more than one fall?

### Activities of Daily Living Scale

☐ Yes ☐ No In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, getting in or out of a bed or chair, or using the toilet?

*If Yes, Everyday Activities that you needed help with:*

☐ Eating
☐ Getting dressed
☐ Bathing
☐ Walking
☐ Getting in and out of bed or a chair
☐ Using the toilet

☐ Yes ☐ No In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medications?

## Review of Symptoms

### Bladder

☐ Yes ☐ No Many people experience problems with urinary incontinence, the leakage of urine. In the past 6 months, have you accidentally leaked urine?

*If Yes to Urine Leakage:*

How much of a problem, if any, was the urine leakage for you?

☐ A Big Problem

☐ A Small Problem

☐ Not a Problem

**Thank You! You have completed the Patient Questionnaire.**