ABCS OF WELLNESS PERSONAL HEALTH SCREENING FORM

NAME: DATE OF BIRTH: / /

		Y	N	If so, please explain
1	Do you have a medical doctor?			
2	Have you seen your medical doctor in the last year?			
3	Have you been hospitalized for medical problems in the past year?			
4	Have you gone to the emergency room for medical care in the last year?			
5	Do you have a dentist?			
6	Do you use over-the-counter medications?			
7	Do you have any allergies to medications or food?			
8	Do you use special equipment or devices?			
9	Have you ever been immunized or vaccinated?			
10	Do you have a special diet?			
11	Do you smoke or chew tobacco?			
12	Do you drink caffeinated beverages?			
13	Do you use street drugs?			
14	Do you exercise regularly?			
15	Are you sexually active?			
16	Do you regularly experience bodily pain that interferes with your daily activities? Please circle face to indicate level of pain.			 1 2 3 4 5
17	Have you or are you taking medication or treatments for pain?			
18	Do you, or anyone in your family, have high blood pressure, hepatitis, high cholesterol, heart attack/heart disease, or diabetes?			

19 Please list all current medications, dose, and prescribing doctor, including medications for pain:

Medication/Dose	Doctor	Medication/Dose	Doctor

20 Please check any of the statements that apply to you:

❑ rashes or sores that don't heal	❑ swollen ankles or feet	❑ difficulty walking
❑ changes in moles or skin	❑ weak or tired all the time	❑ dizzy or frequent falling
❑ finger or toe nail problems	❑ bruise easily or anemic	❑ shaking or trembling
❑ poor hearing	❑ blood sugar problem	❑ numbness or tingling
❑ mouth or teeth problems	❑ stomach pain or upset stomach	❑ frequent headaches
❑ eye or vision problems	❑ nausea or vomiting	❑ seizures
❑ wheezing or shortness of breath	❑ rectal bleeding	❑ confused or forgetful
❑ chest pain or chest tightness	❑ diarrhea or constipation	❑ head injury
❑ frequent cold or coughing	❑ thyroid problem	❑ excessive thirst
❑ positive TB test	❑ painful or difficulty urinating	❑ recent weight gain or loss
❑ high blood pressure	❑ frequent urination	❑ sleep problems
❑ rapid or irregular heart beats	❑ muscle stiffness or pain	❑ mood changes

	not applicable	6 months	1 year	1–2 years	over 3 years	never
21 When was your last prostate exam?						
22 When was your last mammogram?						
23 When was your last pap smear?						
24 When was the last time you had your stool checked for blood?						
25 When was the last time you had your blood checked by a professional?						
26 When was the last time you had your cholesterol checked?						
27 When was the last time you were tested for HIV?						

28 How often do you have a drink containing alcohol?
❑ Never ❑ 1 time/month or less ❑ 2–4 times/month

29 How many drinks containing alcohol do you have on a typical day when you are drinking?
❑ 0 ❑ 1 or 2 ❑ 3 or 4 ❑ 5 or 6 ❑ 7 to 9 ❑ 10 or more

30 How often do you have 6 or more drinks on one occasion?
❑ Never ❑ less than month ❑ monthly ❑ weekly ❑ daily or almost daily

31 How often during the last year have you found that you were not able to stop drinking once you had started?

32 I would rate my overall health as: ❑ EXCELLENT ❑ GOOD ❑ FAIR ❑ POOR

33 To improve my health, I feel I need to:

RECOMMENDATIONS:

❑ Set up an initial visit with primary care physician
❑ Set up a PCP visit to talk about:
❑ Preventive health screening (list specific screening needed)
❑ Evaluation of _____ (list history of symptoms of concern)
❑ Nutrition assessment
❑ Substance abuse evaluation
❑ Smoking cessation
❑ Other: _____

SOURCE Adapted from Washtenaw Community Support and Treatment Services Personal Health Review, Ann Arbor, MI,2004.