






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:

- | | | |
|--|--|---|
| <input type="checkbox"/> rashes or sores that don't heal | <input type="checkbox"/> swollen ankles or feet | <input type="checkbox"/> difficulty walking |
| <input type="checkbox"/> changes in moles or skin | <input type="checkbox"/> weak or tired all the time | <input type="checkbox"/> dizzy or frequent falling |
| <input type="checkbox"/> finger or toe nail problems | <input type="checkbox"/> bruise easily or anemic | <input type="checkbox"/> shaking or trembling |
| <input type="checkbox"/> poor hearing | <input type="checkbox"/> blood sugar problem | <input type="checkbox"/> numbness or tingling |
| <input type="checkbox"/> mouth or teeth problems | <input type="checkbox"/> stomach pain or upset stomach | <input type="checkbox"/> frequent headaches |
| <input type="checkbox"/> eye or vision problems | <input type="checkbox"/> nausea or vomiting | <input type="checkbox"/> seizures |
| <input type="checkbox"/> wheezing or shortness of breath | <input type="checkbox"/> rectal bleeding | <input type="checkbox"/> confused or forgetful |
| <input type="checkbox"/> chest pain or chest tightness | <input type="checkbox"/> diarrhea or constipation | <input type="checkbox"/> head injury |
| <input type="checkbox"/> frequent cold or coughing | <input type="checkbox"/> thyroid problem | <input type="checkbox"/> excessive thirst |
| <input type="checkbox"/> positive TB test | <input type="checkbox"/> painful or difficulty urinating | <input type="checkbox"/> recent weight gain or loss |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> frequent urination | <input type="checkbox"/> sleep problems |
| <input type="checkbox"/> rapid or irregular heart beats | <input type="checkbox"/> muscle stiffness or pain | <input type="checkbox"/> 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? <input type="checkbox"/> Never <input type="checkbox"/> 1 time/month or less <input type="checkbox"/> 2-4 times/month						
29 How many drinks containing alcohol do you have on a typical day when you are drinking? <input type="checkbox"/> 0 <input type="checkbox"/> 1 or 2 <input type="checkbox"/> 3 or 4 <input type="checkbox"/> 5 or 6 <input type="checkbox"/> 7 to 9 <input type="checkbox"/> 10 or more						
30 How often do you have 6 or more drinks on one occasion? <input type="checkbox"/> Never <input type="checkbox"/> less than month <input type="checkbox"/> monthly <input type="checkbox"/> weekly <input type="checkbox"/> 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: <input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> 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.