

ANNUAL HEALTH ASSESSMENT (AHA) QUESTIONNAIRE

HEALTH HISTORY

Have you had a colonoscopy? Yes No Date of Last Colonoscopy: _____
 Who performed the colonoscopy? _____
 Have you had a Cologuard test? Yes No Date of Cologuard test: _____
 Have you had a mammogram? Yes No Date of Last mammogram: _____
 Do you bruise easily? Yes No
 Do you have a history of cancer? Yes No Type of Cancer: _____
 Do you have ongoing cancer treatment? Yes No

EYE

Have you seen an ophthalmologist or optometrist in the past year? Yes No
 Date of last ophthalmologist or optometrist visit: _____
 Name of ophthalmologist or optometrist: _____
 Problems with eyesight? Yes No

PULMONARY

Do you have any wheezing? Yes No
 Do you cough every morning or nearly every morning? Yes No
 How many years have you had a chronic cough and/or produced phlegm? _____ years
 Do you get short of breath with mild exertion? Yes No

SMOKING

Have you ever smoked tobacco? Yes No
 How many packs of cigarettes per day did you or do you currently smoke? _____ packs
 At what age did you start smoking? _____
 How many years have you smoked? _____ years
 Have you stopped smoking? Yes No
 At what age did you stop smoking? _____
 Do you have a history of using smokeless tobacco? Yes No
 How many years have you used smokeless tobacco products? _____ years

CARDIOVASCULAR

Do you have an irregular heartbeat? Yes No
 Do you get shortness of breath at night or when lying down? Yes No
 Have you experienced exercise intolerance? Yes No
 Do you get discomfort, pain, or a pressure or heaviness in the chest? Yes No
 Do you have swelling in your legs? Yes No
 Do you have a history of heart attack(s)? Yes No If yes, what year(s)? ____ ____ ____
 Have you had a coronary artery bypass graft surgery? Yes No If yes, what year? _____
 Have you had coronary stent(s) placed? Yes No If yes, what year(s)? ____ ____ ____
 Do you currently have a pacemaker? Yes No
 Do you have an implanted defibrillator? Yes No If yes, when was it placed? _____
 Do you get pain in your calf muscle(s) when walking that goes away with rest? Yes No
 Have you ever had a vascular stent placed in your legs? Yes No If yes, what year(s)? ____ ____ ____
 If yes, which leg(s)? Left Right



BLADDER FUNCTION

In the past six months, have you experienced leaking of urine? Yes No
If so, how has leaking of urine made you change your daily activities or interfered with your sleep? A lot Somewhat None
Have you ever talked with a provider about leaking of urine? Yes No
Have you ever talked to a provider about ways to control the leaking urine? Yes No

GASTROINTESTINAL

Have you had any recent rectal bleeding or bloody stools? Yes No
Do you have a history of Ulcerative Colitis and/or Crohn's Disease? Yes No
Do you have any recent abdominal pain? Yes No
Have you had any recent changes in your bowel movements? Yes No
Have you ever been treated for chronic hepatitis? Yes No
Do you have a history of cirrhosis? Yes No

FALL RISK

Have you fallen two or more times in the past year? Yes No
During the past year, have you had a problem with balance or walking? Yes No

ALCOHOL & DRUG USE

Do you use medications regularly to sleep? Yes No
Do you use alcohol regularly? Yes No
How much alcohol do you drink in a week? number of drinks: _____
Do you have a history of drug or alcohol dependence? Yes No

Patient/Legal Representative Signature: _____ Date: _____ Time: _____
If signed by other than patient, indicate relationship: _____
Print Name (Legal Representative): _____

FOR STAFF USE ONLY:

DEPRESSION SCREENING

Over the last 2 weeks, how often have you been bothered by little interest or pleasure in doing things?
Not at all (0) Several Days (1) More than half the days (2) Nearly every day (3)

Over the last 2 weeks, how often have you been feeling down, depressed or hopeless?
Not at all (0) Several Days (1) More than half the days (2) Nearly every day (3)

PHQ-2 Score _____ If score is above 3, have patient complete PHQ-9 and notify provider.

COGNITIVE IMPAIRMENT SCREEN

Have you noticed any memory loss that interferes with daily activities? Yes No

MINI-COG

Mini-Cog Score: _____

Staff Signature: _____ Date: _____ Time: _____