Greater Roslindale Medical and Dental Center

Adult Annual Wellness Questionnaire

Our goal is to improve your overall health by discussing preventative care. Therefore, during your Annual Wellness Exam we review your health information, such as your medical problems, past surgeries, and the medical history of the family. Your medical team will work with you to develop your personal health care plan.

Please answer the following questions to the best of your ability.

Name: _____

Date of Birth: _____

Do you have any new medical problems since your last Annual Wellness Exam? Yes No

If "yes" please explain: _____

Do you feel that you understand your medical problems? Yes No

Communication Needs: Please share with us if you have any needs._____

Please review and circle Yes or No to the following questions:

Hearing Problems: Yes No

Vision Problems: Yes No

Trouble thinking or understanding: Yes No

If "yes" please explain: _____

Patient Medical History:

◯ Diabetes
◯ High Blood Pressure
◯ High Cholesterol
◯ Hypothyroidism
◯ Goiter
◯ Cancer (type) _____
◯ Leukemia
◯ Psoriasis
◯ Angina
◯ Heart Problems
◯ Heart Murmur
◯ Pneumonia
◯ Pulmonary Embolism
◯ Asthma
◯ Emphysema
◯ Stroke
◯ Epilepsy (seizures)
◯ Cataracts
◯ Kidney Disease
◯ Kidney Stones
◯ Crohn's Disease
◯ Colitis
◯ Anemia
◯ Jaundice
◯ Hepatitis
◯ Stomach or Peptic Ulcer
◯ Rheumatic Fever
◯ Tuberculosis
◯ HIV / AIDS

◯ Other medical conditions please list: _____

Family History:

Are there medical problems in your family? Yes No

Place an "X" in the appropriate boxes to identify all illnesses/conditions in your family history.

Illness / Condition	**Family Member**							
	Grandparent	**Father**	**Mother**	**Brother**	**Sister**	**Son**	**Daughter**	**Other**
Colon or Rectal Cancer								
Other Cancer								
Heart Disease								
Diabetes								
High Blood Pressure								
Liver Disease								
High Cholesterol								
Alcohol / Drug Abuse								
Depression / Psychiatric Illness								
Genetic (inherited) Disorder								
Other								

What type of place do you live in: House Apartment Other

How much schooling have you had? _____

Do you work: Yes No

Occupation? _____

Do you or your family have concerns about your health? _____

If "yes" please explain _____