

Well-Care Questionnaire for adults on Medicare or age 65+

If you have NOT completed the online Health Profile in the past 6 months, please answer the following questions. Kaiser Permanente values your privacy and will keep your answers confidential. If you don't want to answer a question, feel free to leave it blank.

Full name:	Preferred name:	
What is your gender? ☐ Female ☐ Male ☐ Transfemale ☐ Transmale ☐ Non-binary ☐ Choose not to answer	Pronouns:	Staff: In note, use .genderhealth
Others living in your home (name, age, and relation	ship):	Flow Staff Enter using dot
Please list current providers regularly involved in yo	phrase .wq65	
Do you use medical equipment or prescribed suppl CPAP machine, wheelchair, walker, cane, incontiner others. Yes No If YES, please list equipment and supplies:		
Name of supplier or suppliers: Kaiser Permanento Other	e	
Do you have a signed Living Will? Yes No	☐ Don't know	If documents are
Do you have an up-to-date Durable Power of Attorn Yes No Don't know	presented, send for scanning to Advance Directives Registry.	
How would you describe your general health?		
☐ Excellent ☐ Very Good ☐ Good	☐ Fair ☐ Poor	
On average, how many days per week do you do m gardening or going for a brisk walk?		
On average, how many minutes do you exercise at t	this level each day?	
Do you eat fruits and vegetables every day? Do you eat 2 or more meals every day?	☐ Yes ☐ No ☐ Yes ☐ No	
How would you describe the condition of your moudentures? ☐ Excellent ☐ Very Good ☐ Good	th and teeth, including false teeth or ☐ Fair ☐ Poor	
Do you always fasten your seat belt when you're in a Yes No I don't ride in a car	a car?	
Do you have working smoke detectors on all floors. Are all the stairs at home well lit and do they have have a Yes. Yes. No. Doesn't apply to me		

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DO NOT SCAN IN MEDICAL RECORD

Enter information in note using dot phrase .wq65, then destroy paper form.

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During the past year, have you had any major changes in your life, good or bad? Yes No			
If YES , please explain:			
How often is stress a problem for you in handling such things as your health, finances, family or social relationships, or work? Never Rarely Sometimes Often Always			
Over the last 2 weeks, how often have you been bothered by the following problems?			
Feeling anxious, nervous, or on edge?			
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day			
Not being able to control or stop worrying?			
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day			
Over the last 12 months, how often have you felt angry?			
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always			
How often do you get the social and emotional support you need?			
☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never			
Have you ever used tobacco or nicotine products (cigarettes, chew, or e-cigarettes, vaping device)?	If YES: Complete Tobacco History section in Epic		
☐ Yes ☐ No	If YES to 100		
FOR MEN ONLY: If YES, have you smoked 100 cigarettes or more in your lifetime? Yes No	cigarettes: AAA screening for men age 65-75 if clinically appropriate		
Have you ever had sex? ☐ Yes ☐ No - skip to next section			
Have your sexual partners included:			
│			
Did you use condoms or other barrier during sex?			
☐ Always ☐ Sometimes ☐ Never			
How many sexual partners have you had in the last 3 months?			
Have you been tested for HIV? No Yes			
Are any of your current sexual partners known to be HIV positive: Yes No			
Do you have any concerns about your sexual health or pleasure? 🔲 No 🔲 Yes			
Menstrual History			
Are you: Still having periods Menopausal Taking gender affirming hormones that prevent periods None of these			
If you're no longer having periods:			
Are you taking a daily supplement that has both vitamin D and calcium? Yes No			
Have you had any bleeding since you stopped having periods? Yes No			
Do you have pain with intercourse or orgasm? Tes No			

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Have you fallen 2 or more time	es in the past 12 mor	iths? Yes	☐ No	
Are you here today because of				
Do you have any problems with	h walking or balance	e? Yes	□No	
Do you often ask people to rep Or do you act as if you did hea	-		Yes No	
Do you or does anyone in your memory problems that interfer	-	ou are having Yes	No	
Is urination or leaking urine cau	using any problems	with your daily activit	ies or sleep?	
How many days a week does p	pain or fatigue keep y	you from doing thing	s you like to do?	
0 1-2 days each week	3-4 days each w	veek 🗌 5 or more o	days each week	
Do you need help with any of t	the following?			
Preparing meals	☐ Yes ☐ No	Managing money	☐ Yes ☐ No	
Taking medicine	Yes No	Transportation	☐ Yes ☐ No	
Doing housework	☐ Yes ☐ No	Making and keepin	g appointments	
Shopping for food	☐ Yes ☐ No		☐ Yes ☐ No	
Do you need help with any of t	these?			-
Dressing	Yes No	Using the toilet	☐ Yes ☐ No	
Getting in and out of chairs	☐ Yes ☐ No	Eating	☐ Yes ☐ No	
Bathing	☐ Yes ☐ No	Walking	☐ Yes ☐ No	
Medical and Surgical History				
				Provider or RN
Please list any major illnesses, injuries, or conditions that were treated outside Kaiser Permanente that you haven't told us about in the past.				Enter major illnesses, injuries, or conditions into PMH section or Problem
Please list any major surgeries us about in the past. List each o None	•		at you haven't told	List in Epic as appropriate. Enter major surgeries into PSH section in Epic.
Personal and Family History (t	hose related to you	by blood)		
FOR MEN ONLY:				If YES: AAA
Do you have a parent, brother, or sister who had an abdominal aortic aneurysm? Yes No Don't know				screening for men age 65-75 if clinically appropriate
Do you have a personal or fam Yes No Don't kno If YES, please describe (ie: you	pw -			If YES , give Breast Cancer Risk Questionnaire and complete Epic flowsheet (BCRO)

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Did any of the following family members develop heart disease? Check all that apply. Before age 55: father, brother, or son None before age 55 Don't know Before age 60: mother, sister, or daughter None before age 60 Don't know	
Have you ever had Crohn's disease, ulcerative colitis, colon polyps, or colon cancer? Yes No	If YES: Consult GI.
Have you had a mother, father, sister, brother, daughter, or son diagnosed with the following?	If YES to family history: See Colorectal Cancer
Colon cancer: No Yes - at what age: Don't know	Screening Guideline for screening
Colon polyps: No Yes - at what age: Don't know	recommendations.
Have you had a grandparent, aunt, uncle, niece, or nephew diagnosed with the following?	
Colon cancer: No Yes - at what age: Don't know If YES to either question above, please circle the relative(s) with the condition.	
Do you have a personal or family history of ovarian cancer?	If YES , give Breast
☐ Yes ☐ No ☐ Don't know	Cancer Risk Questionnaire and
If YES, please describe (ie you, which family member):	complete Epic flowsheet (BCRQ)

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