

## ANNUAL HEALTH ASSESSMENT (AHA) QUESTIONNAIRE

Who performed the colonoscopy? Have you had a Cologuard test?	nedical Group					
Who performed the colonoscopy?   Yes   No   Date of Cologuard test:   Have you had a Cologuard test?   Yes   No   Date of Last mammogram:   Do you bruise easily?   Yes   No   Date of Last mammogram:   Do you bruise easily?   Yes   No   Type of Cancer:   Do you have ongoing cancer treatment?   Yes   No   Type of Cancer:   Do you have ongoing cancer treatment?   Yes   No   Type of Cancer:   Do you have ongoing cancer treatment?   Yes   No   Type of Cancer:   Do you seen an ophthalmologist or optometrist visit:   Name of ophthalmologist or optometrist visit:   Name of ophthalmologist or optometrist visit:   Name of ophthalmologist or optometrist:   Problems with eyesight?   Yes   No   Do you cough every morning or nearly every morning?   Yes   No   Do you cough every morning or nearly every morning?   Yes   No   Do you cough every morning or nearly every morning?   Yes   No   No   No   No   No   No   No   N		HEALTH	HISTORY			
Who performed the colonoscopy?   Yes   No   Date of Cologuard test:   Have you had a Cologuard test?   Yes   No   Date of Last mammogram:   Do you bruise easily?   Yes   No   Date of Last mammogram:   Do you bruise easily?   Yes   No   Type of Cancer:   Do you have ongoing cancer treatment?   Yes   No   Type of Cancer:   Do you have ongoing cancer treatment?   Yes   No   Type of Cancer:   Do you have ongoing cancer treatment?   Yes   No   Type of Cancer:   Do you seen an ophthalmologist or optometrist visit:   Name of ophthalmologist or optometrist visit:   Name of ophthalmologist or optometrist visit:   Name of ophthalmologist or optometrist:   Problems with eyesight?   Yes   No   Do you cough every morning or nearly every morning?   Yes   No   Do you cough every morning or nearly every morning?   Yes   No   Do you cough every morning or nearly every morning?   Yes   No   No   No   No   No   No   No   N	Have you had a colonoscopy?	Yes No Date	e of Last Colonoscopy			
Have you had a mammogram?	Who performed the colonoscopy?					
Do you bruise aasily?	Have you had a Cologuard test?		=			
Do you have a history of cancer?			e of Last mammogram	1:		
Do you have ongoing cancer treatment?		= =				
EYE			e of Cancer:			
Have you seen an ophthalmologist or optometrist in the past year?	Do you have ongoing cancer treatment?	☐ Yes ☐ No				
Date of last ophthalmologist or optometrist visit:  Name of ophthalmologist or optometrist:  Problems with eyesigh!?  PULMONARY  Do you have any wheezing?  Do you cough every morning or nearly every morning?  How many years have you had a chronic cough and/or produced phlegm?  Do you eyer smoked tobacco?  How many packs of cigarettes per day did you or do you currently smoke?  At what age did you start smoking?  How many years have you smoked?  Jeans No  How many years have you smoked?  Jeans No  At what age did you stop smoking?  Do you have a history of using smokeless tobacco?  How many years have you used smokeless tobacco?  Yes No  How many years have you used smokeless tobacco?  Yes No  How many years have you used smokeless tobacco?  Yes No  How many years have you repeated an ingift or when lying down?  Have you experienced exercise intolerance?  Do you get discomfort, pain, or a pressure or heaviness in the chest?  Yes No  Do you have a history of heart attack(s)?  Have you have a history of heart attack(s)?  Have you have a history of heart attack(s)?  Have you have a nitinglation?  Do you get plain in your claff muscle(s) when walking that goes away with rest?  Have you ever had a vascular stent placed in your legs?  How pound have a miniplanted defibrillator?  Do you get plain in your calf muscle(s) when walking that goes away with rest?  Have you ever had a vascular stent placed in your legs?  Have you ever had a vascular stent placed in your legs?  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						
Name of ophthalmologist or optometrist:  Problems with eyesight?  PULMONARY  Do you have any wheezing? Do you cough every morning or nearly every morning? How many years have you had a chronic cough and/or produced phlegm? years Do you get short of breath with mild exertion?  SMOKING  Have you ever smoked tobacco? How many packs of cigarettes per day did you or do you currently smoke? How many packs of cigarettes per day did you or do you currently smoke? How many years have you smoked? How many years have you smoked? How many years have you smoked?  Yes No How many years have you smoked?  Yes No O you have a history of using smokeless tobacco? How many years have you used smokeless tobacco? Yes No How many years have you used smokeless tobacco? Yes No How many years have you used smokeless tobacco? Yes No Do you have an irregular heartbeat? 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 wistory of heart latck(s)? Have you have a swelling in your legs? Yes No If yes, what year(s)? Have you had a coronary atery bypass graft surgery? Have you had coronary stent(s) placed? Yes No If yes, what year(s)? Have you have an implanted defibrillator? Yes No If yes, when was it placed? Yes No Do you have an implanted defibrillator? Yes No If yes, what year(s)? Have you ever had a vascular stent placed in your legs? Yes No If yes, what year(s)?						
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SMOKING		-				
SMOKING   Yes   No   No   No   No   No   No   No   N				ars		
Have you ever smoked tobacco? How many packs of cigarettes per day did you or do you currently smoke? packs At what age did you start smoking?	Do you get short of breath with mild exe	rtion?	∐ Yes ∐ No			
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At what age did you start smoking?						
How many years have you smoked?			smoke? pacl	KS		
Have you stopped smoking?  At what age did you stop smoking? Do you have a history of using smokeless tobacco? How many years have you used smokeless tobacco products?						
At what age did you stop smoking?		years	□ Vas □ Na			
Do you have a history of using smokeless tobacco?			162 NO			
How many years have you used smokeless tobacco products?		ss tobacco?	□ Yes □ No			
CARDIOVASCULAR  Do you have an irregular heartbeat?						
Do you have an irregular heartbeat?  Do you get shortness of breath at night or when lying down?  Have you experienced exercise intolerance?  Do you get discomfort, pain, or a pressure or heaviness in the chest?  Do you have swelling in your legs?  Do you have a history of heart attack(s)?  Have you had a coronary artery bypass graft surgery?  Have you had coronary stent(s) placed?  Do you currently have a pacemaker?  Do you currently have a pacemaker?  Do you get pain in your calf muscle(s) when walking that goes away with rest?  Have you ever had a vascular stent placed in your legs?  I yes No  If yes, what year(s)?  If yes, which leg(s)?  If yes, which leg(s)?	·······································					
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If yes, which leg(s)? ☐ Left ☐ Right		ed in vour leas?	= =	If yes, what year(s)?		
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	AHA		<u> </u>	ii yes, willett leg(s): Lett Lingitt		

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PATIENT LABEL

BLADDER	FUNCTION					
In the past six months, have you experienced leaking of urine? If so, how has leaking of urine made you change your daily activition interfered with your sleep? Have you ever talked with a provider about leaking of urine? Have you ever talked to a provider about ways to control the leaking	☐ A lot ☐ Som ☐ Yes ☐ No	newhat				
GASTROIN	ITESTINAL					
Have you had any recent rectal bleeding or bloody stools?  Do you have a history of Ulcerative Colitis and/or Crohn's Disease Do you have any recent abdominal pain?  Have you had any recent changes in your bowel movements?  Have you ever been treated for chronic hepatitis?  Do you have a history of cirrhosis?	Yes       No         Yes       No         Yes       No         Yes       No         Yes       No         Yes       No         Yes       No					
FALL RISK						
Have you fallen two or more times in the past year?  During the past year, have you had a problem with balance or wall	☐ Yes ☐ No king? ☐ Yes ☐ No					
ALCOHOL & DRUG USE						
Do you use medications regularly to sleep?  Do you use alcohol regularly?  How much alcohol do you drink in a week? number of drinks:  Do you have a history of drug or alcohol dependence?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No					
Patient/Legal Representative Signature:						
FOR STAFF	USE ONLY:					
DEPRESSION SCREENING						
Over the last 2 weeks, how often have you been bothered by little  Not at all (0) Several Days (1) More than half the		(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?						
MINI-COG						
Mini-Cog Score:						
Staff Signature:	Date:	Time:				
AHA						

PATIENT LABEL