hoag
Medical Group

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

PATIENT LABEL

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: _____

PATIENT LABEL