SILVER CROSS
MEDICAL GROUP
The way you *should* be treated.

ANNUAL HEALTH HABITS QUESTIONNAIRE

Alcohol: Do you ever drink alcohol? ☐ No ☐ Yes
☐ Daily ☐ 1-2 per week ☐ 3-5 per week ☐ 1-2 per month ☐ 1-2 per year
Have you ever felt like you should cut down on drinking ☐ Yes ☐ No
Have people ever criticized you for drinking? ☐ Yes ☐ No
Do you ever feel bad or guilty about drinking? ☐ Yes ☐ No
Have you ever taken a drink first thing in the morning to ease your nerves or cure a hangover? ☐ Yes ☐No

Tobacco:☐ Never a smoker/Smokeless Tobacco/Electronic Cigarette/Vaping
☐ Current every day smoker/Smokeless Tobacco/Electronic Cigarette/Vaping
☐ Current some days smoker/Smokeless Tobacco/Electronic Cigarette/Vaping
☐ Former Smoker/Smokeless Tobacco/Electronic Cigarette/Vaping Year quit _____ Years smoked _____

Substance Abuse: Do you use recreational/street drugs? ☐ Currently Use ☐ Previously used ☐Never used

Employment: ☐ Employed Full Time ☐ Employed Part Time ☐ Retired ☐ Student ☐Unemployed

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Number of Children _____

Type of Diet: ☐ Regular ☐ Diabetic ☐ Low Fat ☐ Low Carb ☐ Low Salt ☐ Low Calorie ☐ Vegetarian
Other: _____

Caffeine Intake: O None
☐ Coffee_____cups per day ☐ Tea_____cups per day ☐ Cola_____cans per day

Exercise: ☐ Daily ☐ 1-2 times/week _____mins ☐ 3-4 times/week ____mins ☐ 5-6 times/week ___mins

Are you Currently Sexually Active? ☐ Yes ☐ No
If yes: are you trying for pregnancy? ☐ Yes ☐ No Contraceptive method used: _____
Last Menstrual Cycle_____

Mental Health:
In the past TWO WEEKS have you felt down, depressed or hopeless?
☐ Not at all ☐ Several days ☐ Half the days ☐ Nearly Everyday
In the past TWO WEEKS have you felt little interest or pleasure in your daily activities?
☐ Not at all ☐ Several days ☐ Half the days ☐ Nearly Everyday

Do you have an Advanced Directive, Living Will or Power of Attorney? _____
Have you had a pneumonia shot? ☐ Yes ☐ No Date received/where:_____
Do you get a yearly flu shot? ☐ Yes ☐ No Date received/where:_____
Do you live alone? ☐ Yes ☐ No
Have you fallen in the last 3 months ? ☐ Yes ☐ No

Wellness Screenings:
Pap Smear (where/date)_____Mammogram (where/date)_____
Colorectal Screening (Colonoscopy/Fecal Occult Blood Test) where/date_____

Diabetes: Last A1C/Result _____ Last Eye Exam/Where _____ Endocrinologist_____

PATIENT NAME _____DOB_____DATE_____