KAISER PERMANENTE®

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 relationship):		**Flow Staff** Enter using dot phrase .wq65
Please list current providers regularly involved in your medical care.		
Do you use medical equipment or prescribed supplies at home? For example, oxygen, CPAP machine, wheelchair, walker, cane, incontinence supplies, ostomy supplies and others. ☐ Yes ☐ No If YES, please list equipment and supplies: Name of supplier or suppliers: ☐ Kaiser Permanente ☐ Apria ☐ Care Medical ☐ Other_____		
Do you have a signed Living Will? ☐ Yes ☐ **No** ☐ **Don't know** Do you have an up-to-date Durable Power of Attorney for health care? ☐ Yes ☐ **No** ☐ **Don't know**		If documents are 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 moderate to strenuous exercise, like gardening or going for a brisk walk? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ Don't know On average, how many minutes do you exercise at this level each day? _____		
Do you eat fruits and vegetables every day? ☐ Yes ☐ **No** Do you eat 2 or more meals every day? ☐ Yes ☐ **No**		
How would you describe the condition of your mouth and teeth, including false teeth or dentures? ☐ Excellent ☐ Very Good ☐ Good ☐ **Fair** ☐ **Poor**		
Do you always fasten your seat belt when you're in a car? ☐ Yes ☐ No ☐ I don't ride in a car		
Do you have working smoke detectors on all floors of your home? ☐ Yes ☐ **No** Are all the stairs at home well lit and do they have handrails? ☐ Yes ☐ **No** ☐ Doesn't apply to me		

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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)?
☐ **Yes** ☐ No

FOR MEN ONLY:
If **YES**, have you smoked 100 cigarettes or more in your lifetime? ☐ **Yes** ☐ No

If YES: Complete Tobacco History section in Epic

If YES to 100 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:
☐ Men ☐ Women ☐ Transmen ☐ Transwomen ☐ Non-binary people
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? ☐ **Yes** ☐ No

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Have you fallen 2 or more times in the past 12 months? ☐ **Yes** ☐ No Are you here today because of a fall? ☐ **Yes** ☐ No Do you have any problems with walking or balance? ☐ **Yes** ☐ No	
Do you often ask people to repeat what they've said? Or do you act as if you did hear so you don't have to ask for repeats? ☐ **Yes** ☐ No	
Do you or does anyone in your family notice that you are having memory problems that interfere with your life? ☐ **Yes** ☐ No	
Is urination or leaking urine causing any problems with your daily activities or sleep? ☐ **Yes** ☐ No	
How many days a week does pain or fatigue keep you from doing things you like to do? ☐ 0 ☐ 1-2 days each week ☐ **3-4 days each week** ☐ **5 or more days each week**	
Do you need help with any of the following? Preparing meals ☐ **Yes** ☐ No — Managing money ☐ **Yes** ☐ No Taking medicine ☐ **Yes** ☐ No — Transportation ☐ **Yes** ☐ No Doing housework ☐ **Yes** ☐ No — Making and keeping appointments Shopping for food ☐ **Yes** ☐ No — ☐ **Yes** ☐ No	
Do you need help with any of 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

Please list any major illnesses, injuries, or conditions that were treated outside Kaiser Permanente that you haven't told us about in the past. ☐ None	**Provider or RN** Enter major illnesses, injuries, or conditions into PMH section or Problem List in Epic as appropriate. Enter major surgeries into PSH section in Epic.
Please list any major surgeries performed outside Kaiser Permanente that you haven't told us about in the past. List each one and the approximate year. ☐ None	

Personal and Family History (those related to you by blood)

FOR MEN ONLY: Do you have a parent, brother, or sister who had an abdominal aortic aneurysm? ☐ **Yes** ☐ No ☐ Don't know	If **YES**: AAA screening for men age 65-75 if clinically appropriate
Do you have a personal or family history of breast cancer? ☐ Yes ☐ No ☐ Don't know If YES, please describe (ie: you, which family member):	If **YES**, give Breast Cancer Risk Questionnaire and complete Epic flowsheet (BCRQ)

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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? Colon cancer: ☐ No ☐ **Yes – at what age:_____** ☐ Don't know Colon polyps: ☐ No ☐ **Yes – at what age:_____** ☐ Don't know 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.	If YES to family history: See Colorectal Cancer Screening Guideline for screening recommendations.
Do you have a personal or family history of ovarian cancer? ☐ **Yes** ☐ No ☐ Don't know If YES, please describe (ie you, which family member):	If **YES**, give Breast Cancer Risk Questionnaire and complete Epic flowsheet (BCRQ)

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