KAISER PERMANENTE®

Well-Care Questionnaire
for adults aged 22 to 64

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	**Pronouns:**	**Staff:** In note, use .genderhealth

Current or usual occupation:	**STAFF:** Enter using dot phrase .wq22to64
Others living in your home (name, age, and relationship):	
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 a brisk walk or jog? ☐ 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 have any questions or concerns about your eating habits? ☐ **Yes** ☐ No	

Safety

If you ride a motorcycle or bicycle, do you always use a helmet? ☐ Yes ☐ **No** ☐ Doesn't apply to me Do you always use your seat belt when in a car? ☐ Yes ☐ **No** ☐ Doesn't apply to me Do you text while driving? ☐ **Yes** ☐ No ☐ Doesn't apply to me Do you ever drive under the influence of alcohol or drugs, or ride with a driver who is? ☐ **Yes** ☐ No Do you have access to guns? ☐ **Yes** ☐ No If yes, are they stored unloaded and locked? ☐ Yes ☐ **No** ☐ **Don't know**	
Have you ever been a victim of threats, physical hurting, or forced sexual contact? ☐ **Yes** ☐ No Does your partner control where you go or make you feel afraid? ☐ **Yes** ☐ No Have you ever had a partner who physically hurt or threatened you? ☐ **Yes** ☐ No	
During the past year, have you had any major changes in your life, good or bad? ☐ **Yes** ☐ No If **YES**, please explain:	

DO NOT SCAN IN MEDICAL RECORD - Enter information in note using phrase .wq22to64, then destroy paper form.

Tobacco, Nicotine Use

Have you ever used tobacco or nicotine products (cigarettes, chew, e-cigarettes, vaping device)?
☐ No ☐ Yes

If YES: Complete Tobacco History section in Epic

Sexuality

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**
When you have sex, how often do you, or does your partner, use protection from pregnancy other than a condom? ☐ Always ☐ **Sometimes** ☐ **Never** ☐ Doesn't apply to me
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
If you or your partner use protection, what kind:
☐ Condoms ☐ Birth control pills ☐ IUD ☐ Depo-Provera ☐ Other:_____
Surgical method: ☐ Tubal ligation ☐ Vasectomy ☐ Hysterectomy
Do you have any concerns about your sexual health or pleasure? ☐ No ☐ Yes

Many sexually transmitted infections (STI) do not have symptoms you can see or feel. That's why it's important to get tested if you could be at risk. Places that could be infected by an STI include the genitals, anus, throat, and mouth. When we screen for STIs, we routinely test all sites that could be infected. Are there any sites you don't want me to check? ☐ No ☐ Yes

If NO to HIV testing, give handout on Routine HIV Testing

Menstrual, Pregnancy History

Do you have a uterus? ☐ Yes ☐ No
Are you pregnant or do you plan to get pregnant within the next year? ☐ **Yes** ☐ No
If YES, are you taking a daily supplement that has folate (folic acid)? ☐ Yes ☐ **No**
Have you ever been pregnant? ☐ **Yes** ☐ No
If **yes**:
Number of full-term pregnancies:____ Number of miscarriages or abortions: ____

STAFF: Enter using dot phrase .wq22to64

If you're still menstruating, when was your last period (date): _____
Please describe your periods:
☐ Regular ☐ Irregular ☐ Heavy ☐ Painful

If you're no longer having periods:
Are you: ☐ Menopausal ☐ On birth control that prevents periods ☐ Taking gender affirming hormones that prevent periods ☐ None of these
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

If **yes** to pregnancy:
Enter in OB History section of Epic.

Is urination or leaking urine a problem for you? ☐ **Yes** ☐ No

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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	**STAFF:** 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)

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 doc flowsheet (BCRQ)
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)

Advanced Care Planning

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.