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.

Name:

<table>
<thead>
<tr>
<th>Others living in your home (name, age, and relationship):</th>
</tr>
</thead>
</table>

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_________ |

<table>
<thead>
<tr>
<th>Do you have a signed Living Will? □ Yes □ No □ Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have an up-to-date Durable Power of Attorney for health care? □ Yes □ No □ Don’t know</td>
</tr>
</tbody>
</table>

| 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 |
|-----------------------------------------------------------------------------------------------|

<table>
<thead>
<tr>
<th>Do you always fasten your seat belt when you’re in a car? □ Yes □ No □ I don’t ride in a car</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Do you have working smoke detectors on all floors of your home? □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are all the stairs at home well lit and do they have handrails? □ Yes □ No □ Doesn’t apply to me</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During the past year, have you had any major changes in your life, good or bad? □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES, please explain:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>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</th>
</tr>
</thead>
</table>
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 (smoke, chew, or e-cigarettes) or other vapor product?

- [ ] Yes
- [ ] No

**FOR MEN ONLY:**

If [ ] Yes, have you smoked 100 cigarettes or more in your lifetime?

- [ ] Yes
- [ ] No

Have you had sex with a man, a woman, or both?

- [ ] Man
- [ ] Woman
- [ ] Both
- [ ] Never had sex
- [ ] Prefer not to answer

Are any current sexual partners known to be HIV positive?

- [ ] Yes
- [ ] No

Have you had sex with a new partner or partners in the last year?

- [ ] Yes
- [ ] No
- [ ] Prefer not to answer

If [ ] Yes, did you use condoms?

- [ ] Always
- [ ] Sometimes
- [ ] Never

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

If YES: Complete Tobacco History section in Epic

If YES to 100 cigarettes: AAA screening for men age 65-75 if clinically appropriate

Continued on next page
**Well-Care Questionnaire - for adults on Medicare or age 65+**

### Do you need help with any of the following?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing meals</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Taking medicine</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Doing housework</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Shopping for food</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Managing money</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Transportation</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Making and keeping appointments</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### Do you need help with any of these?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Getting in and out of chairs</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Bathing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Using the toilet</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Eating</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Walking</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### 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

**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

- **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):

- **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

- **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.

---

**Continued on next page**
<table>
<thead>
<tr>
<th>Do you have a personal or family history of ovarian cancer?</th>
<th>If YES, give Breast Cancer Risk Questionnaire and complete Epic flowsheet (BCRO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No ☐ Don’t know</td>
<td></td>
</tr>
</tbody>
</table>

If YES, please describe (ie you, which family member):

**DO NOT SCAN IN MEDICAL RECORD**

Enter information in note using dot phrase .wq65, then destroy paper form.