

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:

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. <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please list equipment and supplies: Name of supplier or suppliers: <input type="checkbox"/> Kaiser Permanente <input type="checkbox"/> Apria <input type="checkbox"/> Care Medical <input type="checkbox"/> Other _____	
Do you have a signed Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know Do you have an up-to-date Durable Power of Attorney for health care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	If documents are presented, send for scanning to Advance Directives Registry.
How would you describe your general health? <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
On average, how many days per week do you do moderate to strenuous exercise, like gardening or going for a brisk walk? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> Don't know On average, how many minutes do you exercise at this level each day? _____	
Do you eat fruits and vegetables every day? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you eat 2 or more meals every day? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How would you describe the condition of your mouth and teeth, including false teeth or dentures? <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Do you always fasten your seat belt when you're in a car? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't ride in a car	
Do you have working smoke detectors on all floors of your home? <input type="checkbox"/> Yes <input type="checkbox"/> No Are all the stairs at home well lit and do they have handrails? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Doesn't apply to me	
During the past year, have you had any major changes in your life, good or bad? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always	

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DO NOT SCAN IN MEDICAL RECORD

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

Well-Care Questionnaire - for adults on Medicare or age 65+

<p>Over the last 2 weeks, how often have you been bothered by the following problems?</p> <p>Feeling anxious, nervous, or on edge?</p> <p><input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day</p> <p>Not being able to control or stop worrying?</p> <p><input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day</p>	
<p>Over the last 12 months, how often have you felt angry?</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always</p>	
<p>How often do you get the social and emotional support you need?</p> <p><input type="checkbox"/> Always <input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never</p>	
<p>Have you ever used tobacco (smoke, chew, or e-cigarettes) or other vapor product?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>FOR MEN ONLY:</p> <p>If YES, have you smoked 100 cigarettes or more in your lifetime? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If YES: Complete Tobacco History section in Epic</p> <p>If YES to 100 cigarettes: AAA screening for men age 65-75 if clinically appropriate</p>
<p>Have you had sex with a man, a woman, or both?</p> <p><input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Both <input type="checkbox"/> Never had sex <input type="checkbox"/> Prefer not to answer</p>	
<p>Are any current sexual partners known to be HIV positive? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Have you had sex with a new partner or partners in the last year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer</p> <p>If YES, did you use condoms? <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never</p>	
<p>Have you fallen 2 or more times in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you here today because of a fall? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have any problems with walking or balance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Do you or does anyone in your family notice that you are having memory problems that interfere with your life? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Is urination or leaking urine causing any problems with your daily activities or sleep? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>How many days a week does pain or fatigue keep you from doing things you like to do?</p> <p><input type="checkbox"/> 0 <input type="checkbox"/> 1-2 days each week <input type="checkbox"/> 3-4 days each week <input type="checkbox"/> 5 or more days each week</p>	

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Well-Care Questionnaire - for adults on Medicare or age 65+

Do you need help with any of the following?			
Preparing meals	<input type="checkbox"/> Yes <input type="checkbox"/> No	Managing money	<input type="checkbox"/> Yes <input type="checkbox"/> No
Taking medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Doing housework	<input type="checkbox"/> Yes <input type="checkbox"/> No	Making and keeping appointments	
Shopping for food	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you need help with any of these?			
Dressing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Using the toilet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Getting in and out of chairs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Walking	<input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> None	<p align="center">Provider or RN</p> <p>Enter major illnesses, injuries, or conditions into PMH section or Problem List in Epic as appropriate.</p> <p>Enter major surgeries into PSH section in Epic.</p>
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. <input type="checkbox"/> None	

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

<p>FOR MEN ONLY:</p> <p>Do you have a parent, brother, or sister who had an abdominal aortic aneurysm? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>	<p>If YES: AAA screening for men age 65-75 if clinically appropriate</p>
<p>Do you have a personal or family history of breast cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>If YES, please describe (ie: you, which family member):</p>	<p>If YES, give Breast Cancer Risk Questionnaire and complete Epic flowsheet (BCRQ)</p>
<p>Did any of the following family members develop heart disease? Check all that apply.</p> <p><input type="checkbox"/> Before age 55: father, brother, or son <input type="checkbox"/> None before age 55 <input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> Before age 60: mother, sister, or daughter <input type="checkbox"/> None before age 60 <input type="checkbox"/> Don't know</p>	
<p>Have you ever had Crohn's disease, ulcerative colitis, colon polyps, or colon cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If YES: Consult GI.</p>
<p>Have you had a mother, father, sister, brother, daughter, or son diagnosed with the following?</p> <p>Colon cancer: <input type="checkbox"/> No <input type="checkbox"/> Yes - at what age:____ <input type="checkbox"/> Don't know</p> <p>Colon polyps: <input type="checkbox"/> No <input type="checkbox"/> Yes - at what age:____ <input type="checkbox"/> Don't know</p> <p>Have you had a grandparent, aunt, uncle, niece, or nephew diagnosed with the following?</p> <p>Colon cancer: <input type="checkbox"/> No <input type="checkbox"/> Yes - at what age:____ <input type="checkbox"/> Don't know</p> <p>If YES to either question above, please circle the relative(s) with the condition.</p>	<p>If YES to family history: See Colorectal Cancer Screening Guideline for screening recommendations.</p>

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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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