Wellness Exam Checklist

Name: Kyle Johnson

Date: 09/08/2026 /_____/_____

Date of Birth: 10 /08 /1978

To ensure you receive the best possible healthcare, please complete this wellness assessment before your appointment. Your responses will help your healthcare provider understand your health status and needs.

In the last 4 weeks, to what extent have emotional issues affected you?

- [ ] Not at all
- [ ] A little
- [ ] Somewhat
- [x] Quite a bit
- [ ] Significantly

Over the past 4 weeks, have health limitations impacted your social activities with others?

- [ ] Not at all
- [ ] A little
- [x] Somewhat
- [ ] Quite a bit
- [ ] Significantly

In the past 4 weeks, how would you rate the pain you've experienced?

- [ ] None
- [ ] Very mild
- [x] Mild
- [ ] Moderate
- [ ] Severe

During the past 4 weeks, did you have someone available for support when needed?

- [ ] Yes, as much as needed

- [ ] Yes, to a significant extent
- [x] Yes, to some extent
- [ ] Yes, a little
- [ ] No, not at all

What was the most strenuous physical activity you could perform for at least 2 minutes in the past 4 weeks?

- [ ] Very strenuous
- [ ] Strenuous
- [ ] Moderately strenuous
- [ ] Light
- [ ] Very light

Over the past 4 weeks, how would you rate your overall health?

- [ ] Excellent
- [x] Very good
- [ ] Good
- [x] Fair
- [ ] Poor

How have things been for you in the past 4 weeks?

- [ ] Very well - could hardly be better
- [ ] Pretty good
- [x] Good and bad parts about equal
- [ ] Pretty bad
- [ ] Very bad - could hardly be worse

Do you have difficulties driving?

- [ ] Yes, often
- [x] Sometimes
- [ ] No
- [ ] Not applicable, I do not drive

Do you consistently fasten your seat belt when in a vehicle?

- [x] Yes, usually
- [ ] Yes, sometimes
- [ ] No

How often during the past 4 weeks have you experienced the following issues?

- [x] Feeling dizzy or unstable when standing up
- [ ] Sexual difficulties
- [ ] Trouble eating well
- [ ] Issues with teeth or dentures
- [ ] Problems using the telephone
- [x] Feeling tired or fatigued

Have you experienced two or more falls in the past year?

- [x] Yes
- [ ] No

Are you concerned about falling?

- [x] Yes
- [ ] No

Do you smoke?

- [ ] No
- [x] Yes, and I might quit
- [ ] Yes, but I'm not ready to quit

In the last 4 weeks, how many alcoholic drinks did you have?

- [ ] 10 or more per week
- [x] 6-9 per week
- [ ] 2-5 per week
- [ ] 1 drink or less per week
- [ ] No alcohol at all

Do you engage in exercise for about 20 minutes, three or more days a week?

- [ ] Yes, most of the time
- [x] Yes, some of the time

- [ ] No, I usually do not exercise this much

Have you received information to help with:

- [ ] Identifying potential hazards at home?
- [x] Managing your medications?

How often do you face challenges in taking medications as prescribed?

- [ ] Rarely or never
- [x] Occasionally
- [ ] Often