Wellness Questionnaire Name:	Date:
List all your doctors and medical providers	**Specialty**

List all your medications, including non-prescription meds	**Dose/Strength**	**Frequency**

Have you had any preventive health tests done recently?	yes ( ) no ( )	
Have you had any recent immunizations?	yes ( ) no ( )	
Has your mood changed recently?	yes ( ) no ( )	
Are you worried about falling?	yes ( ) no ( )	
Are you concerned about your memory?	yes ( ) no ( )	
Do you have a Living Will or Advance Directive?	yes ( ) no ( )	