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2024 Annual Wellness Form

The following information is being collected today as part of an Annual Wellness Visit. We understand that some of this information may have already been communicated to the doctor, but we would like to ensure that we keep your medical records up to date. If you have any questions, please let us know.

Patient Name	Date of Birth	Physician Name	Today's Date

SURGERIES/HOSPITALIZATION/INJURIES/TRANSFUSION

ALLERGIES/SEVERITY/REACTIONS

MEDICATIONS

List all medications including OTCs, vitamins/minerals, and dietary supplements including dosage, frequency, and route of administration

PATIENT NAME: DOB: DATE:

FAMILY HISTORY

	Father	Mother	Sibling(s)	Spouse	Grandparents	Other
Hypertension	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐

GENERAL HEALTH & HEALTH MANAGEMENT

In general, would you say your health is:	☐Excellent ☐Good ☐Fair ☐Poor
In general, would you say your hearing is:	☐Excellent ☐Good ☐Fair ☐Poor
Please describe the current condition of your mouth and teeth (includingfalse teeth or dentures)?	☐Excellent ☐Good ☐Fair ☐Poor
In the past 7 days, how much pain have you felt?	☐ None ☐Some ☐A lot
How confident are you that you can control and manage most of yourhealth problems?	☐I do not have any health problems ☐Confident. ☐Somewhat confident ☐Not Very Confident
Current physical activity as compared to last year is?	☐More ☐ Less ☐Same

VACCINATION & IMMUNIZATIONS

Did you receive Flu immunization?	☐ Yes ☐ No ☐ Declined ☐Allergic _____ (Month / Day / Year)
When was your last Tetanus shot?	☐ Yes ☐ No ☐ Declined ☐Allergic _____ (Month / Day / Year)
Have you ever had the Shingles Vaccination(s)?	☐ Yes ☐ No ☐ Declined
Have you ever had a Pneumonia Vaccination?	☐ Prevnar 13 _____ (Month/Day/Year) ☐ Pneumovax 23 _____ (Month/Day/Year) ☐ Yes, but I'm not sure of the type_____ (Month/Day/Year) ☐ No

PATIENT NAME: DOB: DATE:

DIAGNOSTIC HISTORY

Please complete the following section with as much information as possible. Leave a section blank, if the section does not apply to you or if you do not remember the information.

Colonoscopy	(Month / Day / Year)	Physician	☐ Normal ☐ Abnormal ☐ Other Results ☐ Not Applicable due to total Colectomy or colorectal cancer
Diabetic Eye Exam	(Month / Day / Year)	Physician / Clinic	☐ Normal ☐ Abnormal Results
Diabetic HbA1c	(Month / Day / Year)	HbA1c Level	
Eye Exam	(Month / Day / Year)	Physician / Clinic	☐ Normal ☐ Abnormal Results
Echocardiogram	(Month / Day / Year)	Physician	☐ Normal ☐ Abnormal Results
Dental Exam	(Month / Day / Year)	Physician	☐ Normal ☐ Abnormal Results
Bone Density	(Month / Day / Year)	Physician / Facility	☐ Normal ☐ Abnormal Results
Hepatitis C Testing	(Month / Day / Year)	Physician	☐ Normal ☐ Abnormal Results
Prostate Exam	(Month / Day / Year)	Physician	☐ Normal ☐ Abnormal Results
FEMALES ONLY			
Last Mammogram	(Month / Day / Year)	Physician / Facility	☐ Normal ☐ Abnormal Results ☐ Not Applicable due to Bilateral mastectomy or 2 unilateral mastectomies
Pap Smear	(Month / Day / Year)	Physician	☐ Normal ☐ Abnormal Results

PATIENT NAME: DOB: DATE:

ADULT DEPRESSION SCREENING TOOL- PHQ-9 (*If under the age of 18, please request an Adolescent screening tool)*

In the Past 2 weeks:	Not at All	1 – 3 Days	Half the Days	Everyday
I have little interest or pleasure in doing things	0	1	2	3
I'm feeling down, depressed, or hopeless	0	1	2	3
I'm having trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
I'm feeling tired or have little energy	0	1	2	3
I haven't had an appetite or am overeating	0	1	2	3
I'm feeling bad about myself, I feel I've let my family or myself down	0	1	2	3
I have trouble concentrating on things such as reading the paper or watching TV	0	1	2	3
People have noticed that my speech slowed down or is rushed like I am restless	0	1	2	3
I have thoughts I would be better off dead or have thought about hurting myself in someway	0	1	2	3
(OFFICE USE ONLY) **TOTALS** =		+	+	+

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people.	Not at All ☐	Somewhat Difficult ☐	Very Difficult ☐	Extremely Difficult ☐

TOBACCO / ALCOHOL/ OTHER ASSESSMENT

Do you currently use any form of tobacco products (including vape)?	☐ Yes ☐ No
If yes, how many years have you used tobacco products?	_____years
What form of tobacco do you use?	☐ Cigarette ☐Cigar ☐Chew ☐Pipe ☐E-Cig/Vape
How many per day?	_____amount of daily usage
If you do smoke, would you like to quit?	☐ Yes ☐ No
Do you drink alcoholic beverages?	☐ Yes ☐ No
How many per week?	☐ 10 or more ☐ 6-9 per week ☐ 2-5 per week ☐ I do not drink alcohol
Do you drink caffeine?	☐ Yes ☐ No # servings a day _____
Do you use sunscreen?	☐ Yes ☐ No
Do you use recreational drugs?	☐ Yes ☐ No

FALL RISK ASSESSMENT

During the last 12 months, have you fallen 2 or more times?	☐Yes ☐No
During the last 12 months, have you had a fall that resulted in an injury?	☐Yes ☐No
Do you think that you are at high risk for falling?	☐Yes ☐No
Do you use any assistive devices such as a walker, wheelchair or cane?	☐Yes ☐No
Are you having trouble with walking or balance?	☐Yes ☐No
Do you require assistance getting up from a sitting position?	☐Yes ☐No

PATIENT NAME: DOB: DATE:

PAIN ASSESSMENT

Are you experiencing any pain? Pain Level (0-10): _____ Location and description of pain:
Please rate your pain on a scale of 0-10:
(0=No pain 10=unbearable)

Please list any medications that you take for pain: (over the counter or prescribed:

Cardiovascular and Cholesterol Medications

Are you taking ANY of the following medications Prasugrel (Effient), Aspirin, Clopidogrel (Plavix), Ticlopidine (Ticlid), Dipyridamole (Persantine), Ticagrelor (Brillinta)? ☐Yes ☐No

Are you taking a Statin Lipitor (atorvastatin), Zocor (Simvastatin), Crestor (Rosuvastatin), etc.? ☐Yes ☐No

ACTIVITIES OF DAILY LIVING

During the past 4 weeks, was someone available to help you if you needed and wanted help? ☐ No, Not at all ☐ Yes, Sometimes ☐ Yes, Always

In the past 4 weeks, have you had any trouble doing any of the following? If applicable, please list an individual who helped complete the task.

Take medications	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Getting around the home	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Bathing and Dressing	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Using the Telephone	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Traveling	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Grocery Shopping	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Preparing Meals	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Housework	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Managing Money	☐No difficulty ☐Yes, sometimes ☐Yes, Require Assistance from
Do you have a living will?	☐Yes ☐No
Do you have difficulty driving your car?	☐ No, Difficulty ☐ Yes, Sometimes ☐ No, I do not drive
Do you always fasten your seat belt when in a vehicle?	☐ Yes ☐ No
During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?	☐Heavy ☐Moderate ☐Light ☐Very Light
Do you exercise for 20 minutes, 3 or more days a week?	☐Yes, Most of the time ☐Yes, Some of the time ☐No, I do not exercise
Have you been given information to help you with the following: • Hazards in the home which may hurt you? • Keeping track of your medications?	 ☐ Yes ☐ No ☐ Yes ☐ No

PATIENT NAME: DOB: DATE:

Please indicate any of the following Chronic Conditions that apply to you:

Chronic Condition	Date diagnosed	Managing Doctor	Date you last saw doctor	Today Physician Initials
Acquired Hypothyroidism				
Acute Myocardial Infarction				
Alzheimer's				
Senile Dementia				
Anemia				
Asthma				
Atrial Fibrillation				
Benign Prostatic Hyperplasia				
Cataract				
Chronic Kidney Disease				
COPD Chronic Obstructive Pulmonary Disease and Bronchiectasis				
Depression				
Diabetes				
Heart Failure				
Hip/Pelvic Fracture				
Hyperlipidemia				
Hypertension				
Ischemic Heart Disease				
Osteoporosis				
RA/OA (Rheumatoid Arthritis/ Osteoarthritis)				
Stroke / Transient Ischemic Attack				
Female/Male Breast Cancer				
Colorectal Cancer				
Prostate Cancer				
Lung Cancer				
Endometrial Cancer				

PATIENT NAME: DOB: DATE:

LIST OF PHYSICIANS
Optometrist
OB/GYN
Ophthalmologist
Cardiologist
Gastroenterologist
Nephrologist
Oncologist
Orthopedist
Pulmonologist
Rheumatologist
Urologist
Neurologist
Psychiatrist
Home Health Company
CPAP Company
Diabetes Supply Company
Other Supply Companies
Other

PATIENT NAME: DOB: DATE:

RECENT HOSPITALIZATIONS/INPATIENT, OUTPATIENT, EMERGENCY (In last 12 Months)		
DATE	**FACILITY**	**REASON**