PATIENT NAME: DOB: DATE:

2023 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

MEDICAL AND SURGICAL HISTORY/ DATE OF OCCURANCE

ALLERGIES/SEVERITY/REACTIONS

MEDICATIONS

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

FAMILY HISTORY

	Father	Mother	Sibling(s)	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 (including false 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 your health 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

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VACCINATION & IMMUNIZATIONS

Did you receive **last season's (Aug. 1, 2022-March 31, 2023)** Flu immunization?	☐ Yes ☐ No ☐ Declined ☐ Allergic ____/____/____ Month Day Year
Have you received **this season's (Aug. 1, 2023-March 31, 2024)** 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____/____/____ ☐ Pneumovax 23____/____/____ ☐ Yes, but I'm not sure of the type____/____/____ ☐ No

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

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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?	☐ 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

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:

_____

_____

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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

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
Chronic Kidney Disease				
Cancer				
Coronary Artery Disease				
Depression/Anxiety				
Diabetes, (Type 1 or 2)				
Deep Vein Thrombosis				
Genetic Disorder				
Heart Disease				
High Blood Pressure				
Liver Disease				
Osteoporosis				
Paraplegic/Quadriplegic				
Neurological Disorder				
Stroke				
Rheumatoid Arthritis				

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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
Other

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