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Annual Wellness Visit Form

Patient Name _____

*Date of Birth*_____ *Today's Date* _____

1) Doctors: Besides us, which other doctors or medical offices do you see?

Name	What Specialty	For what condition(s)?

2) Physical Health:

Do you have problems with any of the following that impairs day-to-day function? (Circle all that apply)

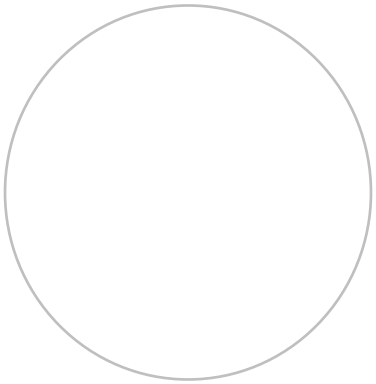
Vision **Hearing** **Memory** **Arm/leg weakness**

Do you need assistance with any of the following? (Circle all that apply)

Bathing **Dressing** **Feeding** **Toileting** **Shopping**

3) Mood: In the last 2 weeks, how often have you felt:

	Not at all	Some days	>4 days	Almost daily
Down or depressed?				
Loss of pleasure/ interest in doing things				



4) Home Safety: Have you fallen in the last year? _____Yes ____ No

Do you have any of the following at home? (Circle all that apply)

Rugs **Poor lighting** **Stairs/steps** **Shower chairs** **Grab Bars**

5) Health care maintenance:

a) As far as you can remember when was your last: b) Have you had the following

Full physical? _____
Colon cancer screen? _____
Bone density (DEXA) scan _____

For females only
Pap smear? _____
Mammogram? _____

For males only
Prostate exam? _____

immunizations?

	Yes	No
Flu (annually)	___	___
Pneumonia (once after 65)	___	___
Shingles (once after 60)	___	___
Tetanus (every 10 years)	___	___
COVID shot	___	___
Others? _____		

6) Social history:

Do you smoke? ____Yes ___No ____ In the past For how many years? _____

Do you drink alcohol? ____Yes If so, how many drinks a night? _____
____Not currently ____ In the past

Do you use any recreational drugs? ____Yes. If so, how often? _____
____Not currently ____ In the past

7) Medications and Supplements:

Please review your med list that's on file today with your provider to make sure it's up to date.

8) Future planning:

Do you have the following?

Advanced Directive _____Yes _____No If yes, do we have a copy? _____
Power Of Attorney _____Yes _____No Who? _____

9) Family History: Please mark all that applies:

Relationship

	SELF	***Mother***	***Father***	***Brother***	***Sister***	***Grandmother***	***Grandfather***
Condition							
Alcoholism							
Cancer *(Type?)*							
Blood pressure *(High)*							
Cholesterol *(high)*							

Diabetes							
Heart Disease							
Mental Illness							
Stroke							
Thyroid							
Others: (please list)							