Name_____________________________________ Chart # _____________ Date ______________________

ANNUAL WELLNESS VISIT

MEDICAL HISTORY: Have you ever had any of the following diseases? **If yes, please give age or year**.

AIDS or HIV+	No__	Yes _____________
Allergies	No__	Yes _____________
Anemia	No__	Yes _____________
Arthritis	No__	Yes _____________
Asthma	No__	Yes _____________
Bleeding disorder	No__	Yes _____________
Blood Clots	No__	Yes _____________
Cancer: Bladder	No__	Yes _____________
Breast	No__	Yes _____________
Colon	No__	Yes _____________
Kidney	No__	Yes _____________
Lung	No__	Yes _____________
Prostate	No__	Yes _____________
Other Cancer	No__	Yes _____________
COPD/ Emphysema	No__	Yes _____________
Depression	No__	Yes _____________
Diabetes	No__	Yes _____________
Diverticulosis/-itis	No__	Yes _____________
Glaucoma	No__	Yes _____________
Gout	No__	Yes _____________
Heart Disease	No___	Yes ________
Heart Attack (MI)	No___	Yes ________
Angioplasty, Stents	No___	Yes ________
Hepatitis	No___	Yes ________
High Cholesterol	No___	Yes ________
High Blood Pressure	No___	Yes ________
Inflammatory Bowel Disease	No__	Yes ________
(Crohn's, Ulcerative Colitis)	No__	Yes ________
Irritable Bowel Syndrome (IBS)	No__	Yes _______
Kidney Disease	No___	Yes ________
Leukemia	No___	Yes ________
Lymphoma	No___	Yes ________
Mental Illness	No___	Yes ________
Osteoporosis	No___	Yes ________
Pneumonia	No___	Yes ________
Rheumatoid Arthritis	No___	Yes ________
Seizures (Epilepsy)	No___	Yes ________
Stroke	No___	Yes ________
Thyroid Disease	No___	Yes ________
Ulcer	No___	Yes ________

SURGICAL HISTORY: Have you ever had any of the following surgeries? **If yes, please give age or year**.

Appendectomy	No__	Yes _____________
Blood Transfusion	No__	Yes _____________
Breast Biopsy	No__	Yes _____________
Breast Surgery	No__	Yes _____________
C-Section	No__	Yes _____________
Cataracts	No__	Yes _____________
Colon	No__	Yes _____________
Gallbladder	No__	Yes _____________
Heart	No__	Yes _____________
Hemorrhoids	No__	Yes _____________
Hernia (list type)	No__	Yes _____________
Hysterectomy	No__	Yes _____________
Kidney	No__	Yes _____________
Prostate	No__	Yes _____________
Thyroid	No__	Yes _____________
Tonsillectomy	No__	Yes _____________
Vasectomy	No__	Yes _____________
Other	No__	Yes _____________

Most Recent Procedures and Results (Normal, Abnormal):

Colonoscopy	Date ___________	Results ____
Endoscopy (EGD)	Date ___________	Results ____
Mammogram	Date ___________	Results ____
Pap Smear	Date ___________	Results ____
DEXA (Bone Density)	Date ___________	Results ____

Name ____________________________________ Chart # _____________ Date ____________________

FAMILY HISTORY:

Father: Alive Y N (circle) Age or Age at Death __________
Mother: Alive Y N (circle) Age or Age at Death ____________
Brother(s) Age(s) and Alive (+) or Deceased (-) (i.e. 67 +, 64 -)_____________________________________
Sister(s) Age(s) and Alive (+) or Deceased (-) ____
Children (B or G) Age(s) ____

Do any of the above family members have or have had: If so, who? (circle all that apply)

Condition	No	Yes	Who	Condition	No	Yes	Who
Alzheimer's	No___	Yes ____	F M B S C	Epilepsy (Seizures)	No___	Yes ____	F M B S C
Aneurysm	No___	Yes ____	F M B S C	Glaucoma	No___	Yes ____	F M B S C
Arthritis	No___	Yes ____	F M B S C	Heart Disease	No___	Yes ____	F M B S C
Breast Cancer	No___	Yes ____	F M B S C	High Blood Pressure	No___	Yes ____	F M B S C
Colon Cancer	No___	Yes ____	F M B S C	High Cholesterol	No___	Yes ____	F M B S C
Ovarian Cancer	No___	Yes ____	F M B S C	Kidney Disease	No___	Yes ____	F M B S C
Prostate Cancer	No___	Yes ____	F M B S C	Multiple Sclerosis	No___	Yes ____	F M B S C
Stomach Cancer	No___	Yes ____	F M B S C	Osteoporosis	No___	Yes ____	F M B S C
Colitis	No___	Yes ____	F M B S C	Psoriasis	No___	Yes ____	F M B S C
Depression	No___	Yes ____	F M B S C	Stroke	No___	Yes ____	F M B S C
Diabetes	No___	Yes ____	F M B S C	Other	No___	Yes ____	F M B S C

SOCIAL HISTORY:

Marital Status: S____ M____ D____ W____
Are you sexually active currently? No____ Yes ____
How many grandchildren do you have? ________
Level of Education Completed: High School___ College ____ Graduate School ____ Other ___________
Previous Occupation: __________________________
Have you ever served in the Military? If so, which branch? _____________________________________
Habits:
- Alcohol; how many drinks per week currently? ______
- Smoker; ever? No__ Yes__ currently? No___ Yes ___ Packs per day? ___ How many years? ___
- Illegal drug use? No ____ Yes _____
- Caffeine: How many cups of coffee or tea per day? ____ How much soda pop per day (cans)? ____
- Exercise: How many days per typical week? _____ Minutes per session?_____Type of exercise?_______________________________
- Special Diet (i.e. low salt or cholesterol)? No _____ Yes ______ Type ________________________
- Number of Fruit and Vegetable servings per day? __________
- Number of servings of fish per typical week? ___________

Immunizations/ Vaccinations:

Vaccine	Yes	No	Year of most recent
Influenza	Yes _____	No _____	Year of most recent_____________
Pneumovax	Yes _____	No _____	Year of most recent_____________
Tetanus	Yes _____	No _____	Year of most recent_____________
Shingles (Zostavax)	Yes _____	No _____	Year of most recent_____________

Other ____

Name ________________________________ Chart # _____________ Date _____________________

CURRENT HEALTHCARE PROVIDERS AND SUPPLIERS: (i.e. Ophthalmologist, Dermatologist, Cardiologist, Medical Supply Company, Home Health Agency)
Please include name, phone number and fax number.

____

____

____

____

____

____

____

____

DEPRESSION SCREENING:

Over the past 2 weeks, have you felt down, depressed or hopeless? Yes______ No _______
Over the past 2 weeks, have you felt little interest or pleasure in doing things? Yes______ No _______

FUCTIONAL ASSESSMENT/SAFETY:

Do you need help with dressing or bathing? Yes_______ No _______
Do you need help with shopping or preparing meals? Yes_______ No _______
Do you need help with housework or laundry? Yes_______ No _______
Do you need help with managing mediations or money? Yes_______ No _______
Do you have problems with poor lighting in your home? Yes_______ No _______
Do you have problems with hearing a one-on-one conversation? Yes_______ No _______
Have you had unexplained falls recently? Yes_______ No _______

ALLERGIES:

Medication and type of reaction (i.e. rash, swelling, stomach upset)

____

____

____

Are you allergic to foods, latex (i.e. exam gloves) or bee stings? Yes __ No ____If yes please detail.

____

____

Name ______________________________ Chart # ___________ Date ___________________

MEDICATIONS: Please list all current prescription and OTC vitamins/supplements including dosages and how often they are consumed.

1.____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

10.____

11.____

12.____

13.____

14.____

15.____

16.____

17.____

18.____

19.____

ADVANCE CARE PLANNING: Do you have advanced directives, such as a Living Will, Power of Attorney for Healthcare, or a DNR form? If you do, please provide a copy of this for your medical record.

Yes __________ No __________

If no, do you want to discuss these forms with the medical staff? Yes _________ No _________

Name________________________________ Chart # ____________ Date ____________________

VITAL SIGNS:

Height _________ Weight ___________ BMI ____________ Blood Pressure ________________

Other ____

SCREENING SCHEDULE:

Abdominal Aneurysm (65-75 if ever a smoker): one time test

Breast Cancer (women): have a mammogram every 1 to 2 years

Cervical Cancer (women): have a Pap smear every 1-3 years. If you are over 65 years and your recent Pap smears have been normal, you do not need a Pap smear

Colorectal Screening: colonoscopy every 10 Yor Flex Sig every 5 Y or FOBT yearly

Diabetes: if Hypertension (high blood pressure) present

High Blood Pressure: have your blood pressure checked every 2 years

High Cholesterol: regularly if you have heart disease risk

HIV: men if sex with men since 1975, if unprotected sex with multiple partners, if you use or have Used IV drugs, if you exchange sex for drugs or money, if you are being treated for a sexually transmitted disease, if you received a blood transfusion between 1978 and 1985

Obesity (BMI): have your body mass index calculated to screen for obesity

Osteoporosis: have a bone density test at age 65; you may need to have this test repeated in 2 years

Sexually Transmitted Disease: if appropriate

Wellness Visit or Complete Physical Examination: yearly

Influenza (Flu) Vaccine: yearly

Pneumovax (Pneumococcal infection): once over age 65

Other:

RISK FACTORS REQUIRING INTERVENTION AND PERSONAL HEALTH ADVICE:

Fall Prevention (lighting, vision, obstacles, etc.)____

Nutrition (more fruits and vegetables, less snacks and sweets) ______________________________

Physical Activity (begin/increase exercise)____

Sleep Habits (caffeine and fluids, activity before or in bed, regular sleep time)__________________

Smoking Cessation (appointment to discuss options when ready to quit)_______________________

Weight Loss (weekly weight diary, food log, counseling)___________________________________

____

____

Please schedule your physical exam to supplement this health assessment (NOTE: the physical exam is not a covered benefit under Medicare, yet this service is recommended for your health)

Physician Signature ____ Date ___________________