**Annual Wellness Visit**

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O. B\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Exam Date: \_\_\_\_\_\_\_\_\_

Allergies to Meds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past personal illnesses, injuries, operations or diagnoses Date Hospitalized?

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Tobacco use YES NO If yes, (smoke or chew) how many packs per day? \_\_\_\_\_\_\_\_\_

Alcohol use YES NO If yes, how many drinks per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug use YES NO If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications, Supplements and Vitamins Route Dose Frequency (Direections)

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\*\* Add additional page if further space for Medications is needed\*\*

Current list of patient’s providers and suppliers

|  |  |  |
| --- | --- | --- |
| NAME | SPECIALTY | REASON |
|  |  |  |
|  |  |  |
|  |  |  |

Family History: particularly Parents, Grandparents, Siblings (check those that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Alcoholism  | Cancer  | High Cholesterol  | Obesity  |
| Arthritis  | Diabetes  | Hypertension  | Stroke  |
| Cancer  | Heart Disease  | Liver or Kidney Disease  | Thyroid Disease  |
| **Additional History/Notes:**  |

Number of servings of fruits and vegetables do you have per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times/week do you exercise? \_\_\_\_\_\_\_\_\_\_ Duration? \_\_\_\_\_\_\_\_\_\_\_\_\_ Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hearing loss screen**

1. Do you have trouble hearing the TV or radio when others don’t? YES NO

1. Do you have to strain or struggle to hear/understand conversations? YES NO

**Function screen**

1. Do you need help with preparing meals, transportation, shopping, taking your meds, managing finances, or other activities of daily living? YES NO

1. Do you live alone? YES NO

**Fall Screen**

1. Have you had an injury from a fall in the last year? YES NO

1. Have you had more then one fall in the last year? YES NO

**Home safety screen**

1. Does your home have rugs, poor lighting, or a slippery bathtub/shower? YES NO

1. Does your home LACK grab bars in bathrooms, handrails on stairs or steps? YES NO

1. Does your home LACK functioning smoke alarms? YES NO

**Advanced care planning**

1. Patient Consent: “I consent to discuss end-of-life issues with my healthcare provider.”

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

 Patient/Guardian Signature Date