ANNUAL WELLNESS VISIT INTAKE FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. For additional information write or attach on back.

Name *(Last, First, M.I.)*:		☐ M ☐ F	**DOB:**		**Date:**

PERSONAL HEALTH HISTORY

MEDICATION HISTORY - List your prescriptions include OTC drugs, such as vitamins and inhalers. ☐ **No medications taken**

Name the Drug	Strength	Frequency	Name the Drug	Strength	Frequency

ALLERGIES- Include antibiotics, narcotics, anesthetics, Iodine, IV, dye, latex, insect bites, stings, food ☐ **No known allergies**

Name	Reaction	Name	Reaction

PAST MEDICAL HISTORY- I have had the following medical conditions: (check all that apply, write in others) ☐ **No health**

Cardiovascular Disease	☐ High Blood Pressure ☐ High Cholesterol ☐ Angina ☐ Heart Attack ☐ Congestive Heart Failure ☐ Heart Valve problem ☐ Rheumatic Heart Disease ☐ Stroke ☐ TIA ☐ Varicose Veins
Endocrine Problems	☐ Diabetes ☐ Thyroid Disorder ☐ Adrenal Gland Disease
Lung Disease	☐ Asthma ☐ COPD ☐ Emphysema ☐ Pneumonia ☐ Sleep Apnea ☐ Tuberculosis ☐ Valley Fever
Musculoskeletal	☐ Arthritis ☐ Chronic Back Pain ☐ Fractures/dislocations ☐ Osteoporosis
Gastrointestinal	☐ Diverticular disease ☐ Esophageal reflux(GERD) ☐ Hepatitis A/B/C ☐ Hemorrhoids ☐ Inflammatory Bowel Disease ☐ Liver problem ☐ Pancreas problem ☐ Ulcer
Kidney disease	☐ Kidney Stones ☐ Renal Failure ☐ Recurrent Urinary Tract Infections
Blood Disorder	☐ Anemia ☐ Blood clots ☐ Blood Transfusion ☐ HIV Positive ☐ AIDS
Infections	☐ Sexually Transmitted Infection ☐ MRSA
Neurologic Diseases	☐ Migraine Headache ☐ Peripheral Neuropathy ☐ Seizures / Epilepsy
Eye Problems	☐ Diabetic Eye disease ☐ Cataracts ☐ Glaucoma
Psychiatric Disorder	☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Eating Disorder
Cancer	List Type:

SPECIALISTS AND HOSPITALIZATIONS	

Doctor/Clinician Signature: ______________________________ Date: ________________

Name (Last, First, M.I.):		DOB:	Date:
Recent Hospitalization in the last year	Date:	Location:	
How many times pregnant?		# Children	

PROCEDURE HISTORY

☐ No Surgeries/Procedures

☐ Appendectomy (Appendix)	Hysterectomy ☐ Partial ☐ Total	☐ Coronary Stent	☐ Vasectomy	☐ Knee Procedure
☐ Tonsillectomy	☐ Cesarean Section	☐ Coronary Bypass	☐ Prostate Procedure	☐ Hip Procedure
☐ Gall Bladder (Cholecystectomy)	☐ Tubal Ligation	☐ Heart Valve Surgery	☐ Colon Procedure	☐ Back Procedure
☐ Hernia Repair	☐ Breast Procedure/Surgery	☐ Cardiac Pacemaker	☐ Eye Procedure	☐ Sinus Procedure
☐ Other Surgeries:				

SOCIAL HISTORY

Tobacco	**Smoking Status:** ☐ Never smoker ☐ Former Smoker ☐ Current every day smoker ☐ Current some day smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Unknown tobacco status	**Tobacco Type:** ☐ Cigarettes ☐ Cigars ☐ Oral ☐ Pipe ☐ Other:	**Describe your daily tobacco use**: ______ # Packs ______ # Cigarettes ______ # Chew/day	Previous Quit Attempts: ☐ None ☐ Counseling ☐ Hypnosis ☐ Medications ☐ Nicotine replacement
	______ Number of Years	_____ Age Started	______ Age Quit	
Caffeine	☐ None ☐ Coffee ☐ Tea	☐ Other:		Amount per day?
Alcohol	Do you drink alcohol? ☐ Yes ☐ No	If yes, what type/amount per week? 2 or more drinks per day?		
Exercise	Type:	Frequency:		
Hobbies	List hobbies, activities and sports:			
Sexuality	☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender			
Drugs	Do you use recreational drugs? ☐ Yes ☐ No	Type:	Amount:	
Marital status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Employment/School	Occupation?	Place of employment/school?		
Personal/Safety	Who do you live with?			
	Do you typically wear a seat belt? ☐ Yes ☐ No			
	Do you have a medical power of attorney? ☐ Yes ☐ No	Do you have a Living Will? ☐ Yes ☐ No		
	Do you feel threatened physically, sexual, verbally in your domestic relationship? ☐ Yes ☐ No			

Doctor/Clinician Signature: ____Date:______________________

Name (Last, First, M.I.):		DOB:	Date:

MEDICARE RISK ASSESSMENT

1) Future Fall Risk Assessment:		2) Cognitive Assessment	
Have you fallen within the last year?	☐ yes ☐ no	Do you experience memory lapses or loss?	☐ yes ☐ no
Do you fall frequently while walking?	☐ yes ☐ no	Do you repeat questions about recent events?	☐ yes ☐ no
Do you get dizzy upon standing?	☐ yes ☐ no	Do you frequently become lost?	☐ yes ☐ no
Do you have difficulty with balance?	☐ yes ☐ no	Do you have difficulty misplacing or finding items?	☐ yes ☐ no
Do you feel unsteady while standing?	☐ yes ☐ no	Do you have difficulty managing medications?	☐ yes ☐ no
Are you afraid of falling?	☐ yes ☐ no	Do you have difficulty managing finances?	☐ yes ☐ no
Do you wake up frequently at night to urinate?	☐yes ☐ no		

3) Activities of Daily Living Assessment	Independent	Require Assistance	Decline in ability
Able to Manage Household	☐	☐	☐
Able to do shopping?	☐	☐	☐
Able to do housecleaning?	☐	☐	☐
Able to do laundry?	☐	☐	☐
Able to do cooking?	☐	☐	☐
Able to drive?	☐	☐	☐
Able to use Public Transportation?	☐	☐	☐
Able to use telephone?	☐	☐	☐

FUNCTIONAL (HISTORY)

Sensory Deficits	☐ None ☐ Blind, left eye ☐ Blind, right eye ☐Cognitive deficit ☐ Hearing deficit, left ☐ Hearing deficit, right ☐ Sensation/touch deficit ☐ Uncorrected visual impairment ☐ Other:
Durable Medical Equipment	List Type (assistive devices, wheelchair, dentures, hearing aids, shower chairs, etc…):

4) Self Care Ability	Independent	Require Assistance	Decline in ability
Ambulation	☐	☐	☐
Chewing skills	☐	☐	☐
Stair Climbing	☐	☐	☐
Bed Mobility	☐	☐	☐
Drinking Skills	☐	☐	☐
Transferring	☐	☐	☐
Hygiene/Bathing	☐	☐	☐
Toileting	☐	☐	☐
Dressing	☐	☐	☐
Eating Skills	☐	☐	☐
Swallowing	☐	☐	☐
Speaking	☐	☐	☐
Cognition	☐	☐	☐

Doctor/Clinician Signature: ____Date:____________________

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FAMILY HISTORY

Do you have a parent, sibling, child with the following? Please select the family member. ☐ **Unknown** ☐ **Adopted**

	Father	Mother	Other- how related?		Father	Mother	Other - how related?	-	Other- How related?
☐ Cancer :Ovarian/Uterine	☐	☐	☐	☐ Osteoporosis	☐	☐	☐		☐
☐ Cancer: Breast	☐	☐	☐	☐ High Blood Pressure	☐	☐	☐		☐
☐ Cancer: Prostate Cancer	☐	☐	☐	☐ Mental Illness	☐	☐	☐		☐
☐ Cancer: Colon	☐	☐	☐	☐ Thyroid Disease	☐	☐	☐		☐
☐ Cancer Other Type?	☐	☐	☐	☐ Stroke	☐	☐	☐		☐
☐ Diabetes	☐	☐	☐	☐ Glaucoma	☐	☐	☐		☐
☐ Heart Disease	☐	☐	☐	☐ Other	☐	☐	☐		☐

PHQ-2 SCREENING (DEPRESSION)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not At All**	**Several Days**	**More than one-half the days**	**Nearly Every Day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

5) VISION TESTING AND HEARING SCREEN

Eye Visual Acuity-Right	
Eye Visual Acuity-Left	
Corrective Lenses	
Eye Corrected Visual Acuity-Right	
Eye Corrected Visual Acuity-Left	
Audiogram screening right	
Audiogram screening left	

HEALTH MAINTENANCE

Women's Health Screening Tests (Most Recent Date)

PAP/Pelvic exam	Date:	☐ Normal ☐ Abnormal-If abnormal PAP smear, what treatment was received?
Mammogram	Date:	☐ Normal ☐ Abnormal
Bone Density(DEXA)	Date:	☐ Normal ☐ Abnormal

Screening Tests (Most Recent Date)

Colonoscopy	Date:	☐ Normal ☐ Abnormal	Stool Blood Test	Date:	☐ Normal ☐ Abnormal
Eye Exam	Date:	☐ Normal ☐ Abnormal	Prostate/Rectal	Date:	☐ Normal ☐ Abnormal

IMMUNIZATIONS

Influenza	☐ Yes ☐ No	Date:	Pneumonia	☐ Yes ☐ No	Date:	Tetanus	☐ Yes ☐ No	Date:
Hepatitis B Series	☐ Yes ☐ No	Date:	Shingles	☐ Yes ☐ No	Date:	Tetanus w/ Pertussis	☐ Yes ☐ No	Date:
Hepatitis A Series	☐ Yes ☐ No	Date:	HPV (human papilloma virus)	☐ Yes ☐ No	Date:	MMR	☐ Yes ☐ No	Date:

PREFERRED PHARMACY

At which pharmacy do you prefer to pick up prescriptions?

Pharmacy Name:	
Address (or cross-streets if address not known)	
City/State:	

Doctor/Clinician Signature: ______________________ Date: ______________

Name (Last, First, M.I.):		DOB:	Date:

REVIEW OF SYMPTOMS: ITEMS DISCUSSED BELOW ARE FOR PROBLEM-FOCUSED VISITS ONLY AND WILL INCUR ADDITONAL PATIENT EXPENSE. BY FILLING THIS OUT, PATIENT UNDERSTANDS THIS IS A SEPARATE CHARGE.		
Please check any of the following you had had within the last 3 month.		
GENERAL	**GASTROINTESTINAL**	**NEUROLOGICAL**
☐ Unintended weight change	☐ Difficulty swallowing	☐ Arm/leg numbness/weakness/tingling
☐ Always tired/fatigue	☐ Abdominal pain	☐ Balance problem/dizziness/vertigo
☐ Appetite change	☐ Nausea	☐ Fainting
☐ Unexplained fever/sweats	☐ Heartburn/Ulcer	☐ Significant headache
☐ Frequent sleep problem	☐ Bloating	☐ Head injury
EYES/EARS/NOSE/THROAT	☐ Vomiting/Vomiting blood	☐ Memory loss/Confusion
☐ Visual change	☐ Diarrhea	☐ Paralysis
☐ Difficulty Hearing	☐ Constipation	☐ Seizures/Convulsions
☐ Earaches	☐ Bloody or black stools	☐ Tremors
☐ Frequent nosebleeds	☐ Special diet	**MUSCULOSKELETAL**
☐ Sneezing	**GENITOURINARY/GYN**	☐ Back Pain
☐ Sore/bleeding gums	☐ Blood in urine	☐ Difficulty walking/Falls
☐ Dental problems	☐ Frequent urination	☐ Joint swelling/Joint Pain
☐ Sore Throat	☐ Painful urination	☐ Muscle Pain
☐ Hoarse	☐ Sexually Transmitted Infection	**SKIN**
☐ Swollen Glands	☐ Penis sore/discharge	☐ Abnormal bleeding/bruising
☐ Wear Glasses/contacts	☐ Testicle pain/lump	☐ Mole color/size change
RESPIRATORY	☐ Sexual difficulty	☐ Change in hair/nails
☐ Cough/Pain with breathing	☐ Urinary loss of control/leaking	☐ Rash/itching/dry
☐ Shortness of breath	☐ Irregular periods	☐ Skin Ulcer
☐ Wheezing	☐ Heavy or painful periods	☐ Acne
☐ Sleeping "propped up"	☐ Vaginal itching/discharge	
☐ Home Oxygen	☐ Hormones after menopause	
	☐ Breast lump	
	☐ Nipple discharge	
CARDIOVASCULAR	**ENDOCRINE**	**PSYCHIATRIC**
☐ Chest pain	☐ Excessive thirst	☐ Anxiety
☐ Chest pain with activity	☐ Heat/cold intolerance	☐ Bothered by feeling down, depressed, or hopeless during the past month
☐ Palpitations/irregular pulse	☐ Changes in voice/hat/glove size	☐ Bothered by little interest or pleasure in doing things during the past month
☐ Leg pain when walking	☐ Steroid use	☐ Suicidal tendencies
☐ Swelling in legs or arms		☐ Victim of abuse physically or sexual
☐ Vein problems		
☐ Other symptoms not listed above:		
☐ **Please check here if all are normal/ negative**		

Patient Signature: ____ **Date:**______________

Doctor/Clinician Signature: ____________________________________Date:____________________