ANNUAL WELLNESS VISIT

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HERITAGE VALLEY HEALTH SYSTEM

We are pleased that you have scheduled your Medicare Annual Wellness Visit.

Please fill out this checklist to help make the most of this appointment with your provider.

Remember: Your Annual Wellness Visit is **NOT** your physical exam. It is a yearly meeting with your provider to discuss your health and to develop a personalized prevention plan.

OFFICE USE ONLY

○ Initial Preventative (G0402)
○ First AWV (G0438)
○ Subsequent AWV (G0439)

Last Name	
First Name	
Date of Birth	Today's Date

Height: _____ Weight: _____ BMI: _____ BP: _____

Visual Acuity: OD _____ OS _____ OU _____

Name: _____ Date of Birth _____ Today's Date: _____

Reminder:

Take all medications with you to your Annual Wellness Visit. This includes:

- √ Prescription drugs
- √ Drugs that you purchase over the counter
- √ All vitamins and supplements
- √ Substances that you place on your body such as ointments or patches

Past Medical History:

Do you currently have, have you had, or have you been diagnosed or treated for any of the following:

	Yes	No		Yes	No
Diabetes	☐	☐	Kidney/Renal Disease	☐	☐
Hypertension	☐	☐	Lupus	☐	☐
Elevated Cholesterol	☐	☐	Rheumatoid Arthritis	☐	☐
Heart Disease	☐	☐	Hemophilia	☐	☐
Aneurysm	☐	☐	Anemia	☐	☐
Blood Clots	☐	☐	Any other Blood Disease	☐	☐
Heart Attack	☐	☐	Colitis	☐	☐
Angina	☐	☐	Colon Polyps	☐	☐
Congestive Heart Failure	☐	☐	GERD	☐	☐
Any Other Heart/Cardiac Condition(s)	☐	☐	Muscular Dystrophy	☐	☐
Asthma	☐	☐	Epilepsy	☐	☐
Emphysema/COPD	☐	☐	Parkinson's Disease	☐	☐
Other Lung Disease	☐	☐	Stroke/CVA/Transient Ischemic Attack	☐	☐
Cancer _____	☐	☐	Alzheimer's/Dementia	☐	☐
Hepatitis	☐	☐	Tuberculosis	☐	☐
Liver Disease	☐	☐	HIV/AIDS	☐	☐

Name: _____ Date of Birth _____ Today's Date _____

Family History – Indicate which relative has had the following diseases:

Disease	Mother	Father	Sister(s)	Brothers(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No Significant history known										
Alcoholism/Drug abuse										
Alzheimers										
Asthma										
Bleeding or Clotting Disorder										
Cancer Breast										
Cancer Colon										
Cancer Ovarian										
Cancer Prostate										
Cancer Other										
Heart Disease/Heart Attack										
Diabetes										
Emphysema (COPD)										
High Blood Pressure-HTN										
Hepatitis B or C										
Hip Fracture										
Osteoporosis										
Thyroid disease										
Depression or Mental Health										

Medication List (Including supplements):

Medication Name	Dosage	Frequency

☐ **See Attached Sheet**

Name: _____ Date of Birth _____ Today's Date _____

1 | **Overall Health**

○ Excellent ○ Good ○ Poor

○ Very Good ○ Fair

2 | **Physical Health (**compared to last year)

○ Much better ○ Same ○ Much worse

○ Slightly better ○ Slightly worse

3 | **Eyesight** (compared to last year)

○ Same ○ Slightly Worse ○ Much worse

4 | **Hearing** (compared to last year)

○ Same ○ Slightly Worse ○ Much worse

5 | **Emotional Health** (compared to last year)

○ Much better ○ Same ○ Much worse

○ Slightly better ○ Slightly worse

6 | **Pain** (in the last 7 days)

How much pain have you experienced?

○ None ○ Some ○ A lot

7 | **Weight** (in the past 6 months)

Have you lost or gained 10 pounds without trying?

○ Yes ○ No

Emotional Health:

During the past month:

1 | **Have you often felt down, depressed or hopeless?**

○ Yes ○ No

2 | **Have you often had little interest or pleasure in doing things?**

○ Yes ○ No

2 | **Have you felt nervous, anxious or on edge?**

○ Yes ○ No

NOTES:

Name: _____ Date of Birth _____ Today's Date _____

Broken Bones/Falls:

Have you?

1 | **Broken a bone?**
○ Yes ○ No

2 | **Had a bone mineral density test?**
○ Yes ○ No

3 | **Fallen within the past year?**
○ Yes ○ No

4 | **If you have fallen within the past year, how many times?** _____

NOTES: _____

Bladder/Bowel:

1 | **In the past six months, have you accidentally leaked urine?**
○ Yes ○ No

2 | **Do you have problems with loss of bowel control?**
○ Yes ○ No

Immunizations:

1 | **Have you had a flu vaccination within the past year ?**
○ Yes ○ No

2 | **Have you had a pneumonia shot?**
○ Yes ○ No

3 | **Have you had a shingles vaccination?**
○ Yes ○ No

4 | **When was your last tetanus/diphtheria shot?**
Date: _____

Name: _____ Date of Birth _____ Today's Date _____

Preventive Screenings:

Have you had any of the following?

1 | **Breast cancer screening** (Mammogram)**?**

○ Yes ○ No

Date: _____

2 | **Prostate Cancer screening**(men only)**?**

○ Yes ○ No

Date: _____

3 | **Colon cancer screening?**

○ Yes ○ No

Date: _____

4 | **Cholesterol screening?**

○ Yes ○ No

Date: _____

5 | **Glaucoma eye exam screening?**

○ Yes ○ No

Date: _____

NOTES:

Home Safety:

1 | **Do you have trouble with the stairs inside or outside your home?**

○ Yes ○ No

2 | **Do you have hazards inside the home such as a lack of grip bars in the bathtub, loose rugs or poor lighting?**

○ Yes ○ No

3 | **Does your home have working smoke alarms?**

○ Yes ○ No

Name: _____ Date of Birth _____ Today's Date _____

Activities of Daily Living:

Can you?

1 | **Get out of bed by yourself?**
○ Yes ○ No

2 | **Dress yourself?**
○ Yes ○ No

3 | **Make your own meals?**
○ Yes ○ No

4 | **Do your own shopping?**
○ Yes ○ No

5 | **Bathe yourself?**
○ Yes ○ No

6 | **Do your laundry/housekeeping?**
○ Yes ○ No

7 | **Manage your money, pay your bills and track your expenses?**
○ Yes ○ No

8 | **Take your medications as directed by your doctor?**
○ Yes ○ No

NOTES:

Name: _____ Date of Birth _____ Today's Date _____

Nutrition:

In the past 7 days:

1 | **How many servings of fruits and vegetables do you typically eat each day?**
_____ serving(s)/day

2 | **How many servings of high-fiber foods or whole grains do you typically eat each day?**
_____ serving(s)/day

3 | **How many servings of fried or high-fat foods do you typically eat each day?**
_____ serving(s)/day

4 | **How many sugar-sweetened beverages do you typically consume each day?**
_____ serving(s)/day

NOTES:

Lifestyle Choices:

1 | **Do you currently smoke or use tobacco products?**
○ Yes ○ No

2 | **Have you smoked or used other tobacco product in the past?**
○ Yes ○ No
If yes, when did you stop? **_____**

3 | **Do you drink alcohol?**
○ Yes ○ No
If yes, how many drinks per week? **_____**

4 | **Do you drive?**
○ Yes ○ No

5 | **Do you use seat belts?**
○ Yes ○ No

6 | **Describe your level of physical activity:**

Name: _____ Date of Birth _____ Today's Date _____

List of Doctors:

Please list any doctors you have seen over the past year and the medical problem that was/is being treated.

Doctor Name:	Specialty:	Reason:

Hospitalizations and Emergency Room Visits in the Past Year:

Date of Visit:	Problem:

Name: _____ Date of Birth _____ Today's Date_____

Advance Directives:

1 | **Have you decided who would speak for you and make health care treatment choices for you if you become ill and could not make them for yourself?**

○ Yes ○ No

2 | **Have you spoken to that person about your choices?**

○ Yes ○ No

3 | **Have you completed a written advance directive, that is, a living will and/or health care power of attorney?**

○ Yes ○ No

NOTES:

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Social Support:

Do you have someone who helps you manage your health care, like a friend or family member? If yes, please provide their contact information.

Health Contact Name		
Street Address		
City	State	ZIP Code
Telephone Number (*with area code*)		

You have a partner in health....

Thank you for completing this checklist. You should feel good about being proactive! Following through with preventative care is one of the best things you can do for your well-being.

Your health is important. Heritage Valley is here to help protect it with resources, information, and the personal support you need.

For Office Use Only

Educational Materials Given:

☐ Women's Prevention

☐ Men's Prevention

☐ Other Instructions: _____

_____

☐ **Plan of Care:**

☐ See Electronic Health Record

_____

_____

_____

Reviewed by: _____ Date: _____

Physician Signature: _____ Date: _____