# ANNUAL WELLNESS VISIT

Uniquely Connected. For life.℠
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

NOTES:

_____

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## Emotional Health:

*Over the past two weeks, how often have you been bothered by any of the following problems?*

| **Question** | Not At All | Several Days | More Than Half the Days | Nearly Every Day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | **0** | **1** | **2** | **3** |
| 2. Feeling down, depressed or hopeless | **0** | **1** | **2** | **3** |
| **OVERALL SCORE** | | | | |

** Notify provider of score*

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 use illicit drugs?**
○ Yes ○ No

5 | **Do you drive?**
○ Yes ○ No

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

7 | **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:

Name: _____ Date of Birth _____ Today's Date_____

## 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 ☐ Other Instructions: _____

☐ Men's Prevention

_____

☐ **Plan of Care (HVMG POC Document):** ☐ See Electronic Health Record

_____

_____

_____

Reviewed by: _____ Date: _____

Physician Signature: _____ Date: _____