HVHN ANNUAL WELLNESS VISIT

Reminder: 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.
√ Please fill out this Annual Wellness Visit form and bring it with you to your scheduled appointment.
√Please bring all medications with you to your Annual Wellness visit including: Prescription medications, over-the-counter medications, Vitamins and Supplements, and medications that you place on your body such as ointments or patches.

Patient's Last Name:	
Patient's First Name:	
Patient's Date of Birth:	**Today's Date:**

OFFICE USE ONLY	☐ **Initial Preventative-IPPE (G0402)**	☐ **First AWV (G0438)**	☐ **Subsequent AWV (G0439)**
Height:	**Weight:**	**BMI:**	**BP:**
Visual Acuity (IPPE Only):	**Right Eye:**	**Left Eye:**	**Both Eyes:**
☐ **Self-reported by patient**		☐ **Unable to obtain due to COVID-19 public health emergency**	

Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM

Patient's Name: _____DOB:_____Date: _____

PATIENT'S MEDICAL HISTORY: Please check all that apply.			
Condition	**√ if Yes**	**Condition**	**√ if Yes**
Abnormal Bleeding	☐	Heart Disease	☐
Alzheimer's/Dementia	☐	Hepatitis	☐
Anemia	☐	High Blood Pressure	☐
Aneurysm	☐	High Cholesterol	☐
Asthma	☐	HIV/AIDS	☐
Blood Clots	☐	Joint Problems	☐
Cancer _____	☐	Kidney Disease	☐
Colon Polyps	☐	Liver Disease	☐
Congestive Heart Failure	☐	Organ Transplant	☐
COPD or Emphysema	☐	Opioid Use Disorder (OUD)	☐
Depression or Anxiety	☐	Pacemaker	☐
Diabetes	☐	Parkinson's Disease	☐
Epilepsy	☐	Rheumatoid Arthritis	☐
GERD/Reflux	☐	Stroke/CVA/TIA	☐
Heart Attack	☐	Thyroid Disorder	☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐
	☐		☐

Patient's Name: _____DOB:_____Date: _____

PATIENT'S FAMILY HISTORY: Check all that apply and indicate family member: Mother, Father, Brother, Sister, Son, and/or Daughter.					
Condition	√ if **Yes**	**Relation**	**Condition**	√ if **Yes**	**Relation**
Abnormal Bleeding or Clotting	☐		Heart Disease/Heart Attack	☐	
Alcoholism/Drug Use	☐		High Blood Pressure/HTN	☐	
Alzheimer's/Dementia	☐		High Cholesterol	☐	
Asthma	☐		Joint Problems	☐	
Cancer_____	☐		Opioid Use Disorder (OUD)	☐	
Congestive Heart Failure	☐		Osteoporosis	☐	
COPD or Emphysema	☐		Stroke/CVA/TIA	☐	
Depression or Anxiety	☐		Thyroid Disorder	☐	
Diabetes	☐			☐	
	☐			☐	
	☐			☐	
	☐			☐	
	☐			☐	
	☐			☐	

PATIENT'S ALLERGIES: Please list all allergies and reactions.	
Allergy	**Reaction-What happens?**

Patient's Name: _____DOB:_____Date: _____

PATIENT'S MEDICATIONS:		
1) Do you understand why you are prescribed your medications?	☐ Yes	☐ No
2) Are you taking your medications as directed by your doctor?	☐ Yes	☐ No
3) Do you experience any side effects from your medications? If yes, please explain:	☐ Yes	☐ No
4) Are you concerned about the cost of your medications?	☐ Yes	☐ No
5) Do you ever forget to take your medications?	☐ Yes	☐ No
Comments:		

PATIENT'S MEDICATION LIST: Including Supplements.

Medication Name	Dosage	Frequency

☐See Attached Sheet for Medication List

STAFF USE ONLY:		
3) Is patient currently prescribed Opioid medication for pain?	☐ Yes	☐ No
If yes, please describe below:		

Patient's Name: _____DOB:_____Date: _____

PATIENT'S LIST OF DOCTORS: Please list any Doctors you have seen over the past year and the medical problem that is/was being treated.		
Doctor's Name	**Specialty**	**Reason**

PATIENT'S HOSPITALIZATIONS: Please list any Hospitalizations and Emergency Room Visits in the Past year.	
Date of Visit	**Problem**

PATIENT'S SURGICAL HISTORY: Please list past surgeries.	
Date of Surgery	**Problem**

MEDICAL SUPPLIES: Example-Oxygen, Wound Care.	
Condition	**Supplier**

IN-HOME SUPPORTS: Example-Home Care Nurse, Physical Therapist.	
Service Provided	**Agency**

Patient's Name: _____DOB:_____Date: _____

OVERALL HEALTH: How would you rate the following?					
1) Overall Health	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
2) Physical Health (compared to last year.)	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
3) Eyesight (compared to last year.)	☐ Same	☐ Slightly Worse	☐ Much Worse		
4) Wears Corrective Lenses?	☐ Yes	☐ No			
5) Hearing (compared to last year.)	☐ Same	☐ Slightly Worse	☐ Much Worse		
6) Wears Hearing Aids?	☐ Yes	☐ No			
7) Emotional Health (compared to last year.)	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
8) How much pain have you had over the past 7 days?	☐ None	☐ Very Mild	☐ Mild	☐ Moderate	☐ Severe
Comments:					

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) Felt down, depressed or hopeless?	☐ 0	☐ +1	☐ +2	☐ +3
2) Had little interest in doing things?	☐ 0	☐ +1	☐ +2	☐ +3
OVERALL SCORE		****Notify Provider of score. **If overall score is greater than 3, complete the PHQ9.**		

3) Do you experience loneliness or isolation?	☐ Yes	☐ No
Comments:		

BROKEN BONES/FALLS:		
1) Have you broken a bone?	☐ Yes	☐ No
2) Have you had a Bone Mineral Densitytest/DEXA?	☐ Yes	☐ No
3) Have you fallen within the past year?	☐ Yes	☐ No
4) If so, how many times?		
5) Do you use a cane or walker?	☐ Yes	☐ No
Comments:		

Patient's Name: _____DOB:_____Date: _____

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
Comments:		

IMMUNIZATIONS:		
1) Have you had a Flu shot within the past year?	☐ Yes	☐ No
2) Have you had a Pneumonia shot?	☐ Yes	☐ No
3) Have you Had a Shingles shot?	☐ Yes	☐ No
4) When was your last Tetanus/Diphtheria Shot? Date: _____		
Comments:		

PREVENTATIVE SCREENINGS:		
1) Have you had a Mammogram/Breast Cancer Screening (Women Only)? Date:	☐ Yes	☐ No
2) Have you had a Prostate Cancer Screening (Men Only)? Date:	☐ Yes	☐ No
3) Have you had a Colon Cancer Screening? Date:	☐ Yes	☐ No
4) Have you had a Cholesterol Screening? Date:	☐ Yes	☐ No
5) Have you had a Glaucoma Eye Screening? Date:	☐ Yes	☐ No
Comments:		

HOME SAFETY:		
1) Do you have trouble with stairs inside or outside of 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
Comments:		

Patient's Name: _____DOB:_____Date: _____

ACTIVITIES OF DAILY LIVING:		
1) Do you get out of bed by yourself?	☐ Yes	☐ No
2) Do you dress yourself?	☐ Yes	☐ No
3) Do you make your own meals?	☐ Yes	☐ No
4) Do you do your own shopping?	☐ Yes	☐ No
5) Do you bathe yourself?	☐ Yes	☐ No
6) Do you do your laundry/housekeeping?	☐ Yes	☐ No
7) Do you manage your money, pay your bills and track your expenses?	☐ Yes	☐ No
Comments:		
STAFF USE ONLY:		
Any decline in cognitive function or memory through direct observation?	☐ Yes	☐ No
Comments:		

NUTRITION:		
1) Any Food/Dietary restrictions?	Please list:_____	
2) Any concerns about nutrition?	Please list:_____	
3) Are you worried that your food will run out before you have money to buy more?	☐ Yes	☐ No
Comments:		

LIFESTYLE CHOICES:		
1) Do you currently smoke or use tobacco products?	☐ Yes	☐ No
2) Have you smoked or used other tobacco products in the past?	☐ Yes	☐ No
3) If yes, when did you stop?		
4) Do you use Medical Marijuana?	☐ Yes	☐ No
5) Do you drink alcohol?	☐ Yes	☐ No
6) If yes, how many drinks/week?		
7) Do you use illegal drugs?	☐ Yes	☐ No
8) If yes, what substances?		
9) Do you drive?	☐ Yes	☐ No
10) Do you use seat belts?	☐ Yes	☐ No
11) Describe your level of physical activity:_____		
Comments:		

Patient's Name: _____DOB:_____Date: _____

ADVANCED DIRECTIVES:		
1) Have you decided who would speak for you and make health care treatment choices for you if you became 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
4) Do you have someone who helps you manage your healthcare, like a friend or family member?	☐ Yes	☐ No
5) If yes, please provide their Name: _____ Address:_____ Phone Number: _____		
Comments:		

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.

OFFICE USE ONLY
☐ See Patient's Personal Preventative Wellness Plan &Counseling and Referrals/Plan of Care Recommendations Sheet
☐ See Electronic Health Record
☐ The patient has verbally consented to participate in the communication technology-based service.
☐ The service was performed using an interactive, real-time telehealth session which included both audio and video. Patient location: _____ Provider location: _____
☐ The service was performed using telephone, audio-only. A video connection with the patient is not possible.
Reviewed by/Credentials: _____Date: _____
Provider Signature: _____Date: _____

****Scan Paper Copy of Annual Wellness Visit into Patient's Electronic Health Record.**

****Scan Paper Copy of Patient's Personal Preventative Wellness Plan & Counseling and Referrals/Plan of Care Recommendations Sheet into Patient's Electronic Health Record.**