AFM 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.

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| Pt Name: |
| Date of Birth: Todays: Date: |

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| **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: |  |  |

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| **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. Include Eye Doctor and Dentist.** | | |
| Doctor’s Name | Specialty | Reason |
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| |  | | --- | | **PATIENT’S HOSPITALIZATIONS: Please list any Hospitalizations and Emergency Room Visits in the Past year.** | | |
| Date of Visit | Problem |
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| **PATIENT’S SURGICAL HISTORY: Please list past surgeries**. Add any updates since last AWV**.** | |
| Date of Surgery | Problem |
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| **MEDICAL SUPPLIES: Example-Oxygen, Wound Care.** | |
| Condition | Supplier |
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| **IN-HOME SUPPORTS: Example-Home Care Nurse, Physical Therapist.** | |
| Service Provided | Agencies |
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| **IMMUNIZATIONS** | | |
| 1. Have you had a Flu shot within the past year? | [ ] Yes | [ ] No |
| 1. Have you had a Pneumonia shot? | [ ] Yes | [ ] No |
| 1. Have you had a shingles shot? | [ ] Yes | [ ] No |
| 1. When was your last Tetanus/Diphtheria shot? Date: | | |
| 1. Have you received any COVID vaccinations? Brand: Dates: | | |
| Comments: | | |

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| |  | | --- | | **OVERALL HEALTH: How would you rate the following?** | | | | | | |
| |  | | --- | | 1) Overall Health- compared to last year. | | [ ] 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 | [ ] Better  (Cataract Surgery) | |
| 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 |
| 9) Weight (in the past 6 months)  Have you lost or gained 10 lbs without trying? | [ ] Yes | [ ] No |  | | |

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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) 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: | | | | |

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| **BROKEN BONES/FALLS:** | | |
| 1. Have you broken a bone above 50 years of age? | [ ] Yes | [ ] No |
| 1. Have you fallen within the past year? | [ ] Yes | [ ] No |
| If so, how many times? Any injuries? | | |
| 1. Do you use a cane or walker? | [ ] Yes | [ ] No |
| 1. Have you had any previous falls? | [ ] Yes | [ ] No |
| **OFFICE USE ONLY** | | |
| 5) Up & Go Test Unsteady/>30 sec?  Unable to obtain Up & Go Test this visit due to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ] Yes | [ ] No |

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| **BLADDER/BOWEL** | | |
| 1. In the past six months, have you accidentally leaked urine? | [ ] Yes | [ ] No |
| 1. Do you have problems with loss of bowel control? | [ ] Yes | [ ] No |
| Comments: | | |

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| **PREVENTATIVE SCREENINGS** | | |
| 1) Have you had a Mammogram/Breast cancer screening)? (Women 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 |
| 1. Have you had a Glaucoma Eye screening?   Date: | [ ] Yes | [ ] No |
| 1. Have you had a Bone Mineral Density Test (DEXA) ? | [ ] Yes | [ ] No |

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| **HOME SAFETY** | | |
| 1) Do you have trouble with stairs or have no stair rails inside or outside your home? | [ ] Yes | [ ] No |
| 2) Do you have hazards inside your home such as a lack of grab bars in the bathroom, loose rugs, poor lighting, uneven floors, household clutter, or unfamiliar surroundings? | [ ] Yes | [ ] No |
| 3) Does your home have working smoke alarms? | [ ] Yes | [ ] No |
| 4) Does your home have working carbon monoxide detectors? | [ ] Yes | [ ] No |
| Comments: | | |

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| **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 own laundry/housekeeping? | [ ] Yes | [ ] No |
| 7) Do you manage your money, pay your bills and track your expenses? | [ ] Yes | [ ] No |
| Comments: | | |

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| **NUTRITION** | | | | |
| 1)Any food/dietary restrictions? | [ ] Yes [ ] No | | If Yes, Please List: | |
| 2)Any concerns about nutrition? | [ ] Yes [ ]No | If Yes, Please List: | | |
| 3)Are you worried that your food will run out before you have money to buy more? | | | | [ ] Yes [ ] No |
| Comments: | | | | |

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| **LIFESTYLE CHOICES** | | |
| 1)Do you currently smoke or use tobacco products? | [ ] Yes | [ ] No |
| 2)Have you smoked or used other p\tobacco products in the past? | [ ] Yes | [ ] No |
| 3)If Yes, when you did stop?  How many years smoked? How many packs per day? | | |
| 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: | | |

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| **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 |
| 1. If yes, please provide their:   Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. Have you given a copy of your advance directives to your provider?   On File? | [ ] Yes  [ ] Yes | [ ] No  [ ] No |
| Comments: | | |

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| 1. What is your living situation today?   Comments: | I have a steady place to live.  I have a place to live today, but I am worried about losing it in the future.  I do not have a steady place to live (I am staying with others, in a hotel, in a shelter, living outside on the street, or in a car.) |
| 1. Think about the place you live. Do you have problems with any of the following? (Check all that apply.)   Comments: | Bug infestation  Mold  Lead paint or pipes  Problems with heat  Oven or stove not working  No or not working smoke detectors  Water leaks  None of the above |
| 1. In the past 12 months, has the electric, gas, oil or water company threatened to shut off your services in your home?   Comments: | Yes  No  Already shut off |
| 1. In the past 12 months, are you worried that your food will run out before you have money to buy more?   Comments: | Yes  No |
| 1. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things you need for daily living?   Comments: | Yes  No |
| 1. In the past 12 months, did you have trouble affording your medications?   Comments: | Yes  No |
| 1. In the past 12 months, has anyone physically or verbally hurt you?   Comments: | Yes  No |
| 1. Do you want help finding or keeping work or a job?   Comments: | Yes  No |
| 1. Would you like help with any of the above?   Comments: | Yes  No |

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.