

# 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.

<b>Patient's Last Name:</b>	
<b>Patient's First Name:</b>	
<b>Patient's Date of Birth:</b>	<b>Today's Date:</b>

<b>OFFICE USE ONLY</b>	<input type="checkbox"/> Initial Preventative-IPPE (G0402)	<input type="checkbox"/> First AWV (G0438)	<input type="checkbox"/> Subsequent AWV (G0439)
<b>Height:</b>	<b>Weight:</b>	<b>BMI:</b>	<b>BP:</b>
<b>Visual Acuity (IPPE Only):</b>	<b>Right Eye:</b>	<b>Left Eye:</b>	<b>Both Eyes:</b>
<input type="checkbox"/> Self-reported by patient		<input type="checkbox"/> Unable to obtain due to COVID-19 public health emergency	

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

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

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

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

<b>PATIENT'S ALLERGIES: Please list all allergies and reactions.</b>	
<b>Allergy</b>	<b>Reaction-What happens?</b>

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

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

<b>PATIENT'S MEDICATION LIST: Including Supplements.</b>		
<b>Medication Name</b>	<b>Dosage</b>	<b>Frequency</b>

See Attached Sheet for Medication List

<b>OFFICE USE ONLY:</b>		
1) Is patient currently prescribed Opioid medication for pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2) If yes to above, have you assessed and discussed Non-Opioid or alternative pain therapies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please describe below:		

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

<b>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.</b>		
<b>Doctor's Name</b>	<b>Specialty</b>	<b>Reason</b>

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

<b>PATIENT'S SURGICAL HISTORY: Please list past surgeries.</b>	
<b>Date of Surgery</b>	<b>Problem</b>

<b>MEDICAL SUPPLIES: Example-Oxygen, Wound Care.</b>	
<b>Condition</b>	<b>Supplier</b>

<b>IN-HOME SUPPORTS: Example-Home Care Nurse, Physical Therapist.</b>	
<b>Service Provided</b>	<b>Agency</b>

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

<b>OVERALL HEALTH: How would you rate the following?</b>					
1) Overall Health	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
2) Physical Health (compared to last year.)	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
3) Eyesight (compared to last year.)	<input type="checkbox"/> Same	<input type="checkbox"/> Slightly Worse	<input type="checkbox"/> Much Worse		
4) Wears Corrective Lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
5) Hearing (compared to last year.)	<input type="checkbox"/> Same	<input type="checkbox"/> Slightly Worse	<input type="checkbox"/> Much Worse		
6) Wears Hearing Aids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
7) Emotional Health (compared to last year.)	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
8) How much pain have you had over the past 7 days?	<input type="checkbox"/> None	<input type="checkbox"/> Very Mild	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
9) Weight (in the past 6 months) Have you lost or gained 10 lbs without trying?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Comments:					

<b>EMOTIONAL HEALTH: Over the past two weeks, how often have you been bothered by any of the following problems?</b>				
Question	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1) Felt down, depressed or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3
2) Had little interest in doing things?	<input type="checkbox"/> 0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3
<b>OVERALL SCORE</b>	<b>**Notify Provider of score.</b> <b>**If overall score is greater than 3, complete the PHQ9.</b>			

3) Do you experience loneliness or isolation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments:		

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

<b>BROKEN BONES/FALLS:</b>		
1) Have you broken a bone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2) Have you had a Bone Mineral Density test/DEXA?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3) Have you fallen within the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4) If so, how many times?		
5) Do you use a cane or walker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6) Have you had any previous falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>OFFICE USE ONLY:</b>		
7) Polypharmacy (concurrent use of multiple meds)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8) Sedative use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9) Have any mobility impairment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10) Do you use alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11) Deconditioning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12) Do you have visual impairment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13) Antidepressant Use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14) Postural Hypotension?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15) Antihypertensive Use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16) Up&Go Test Unsteady/>30 sec?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unable to obtain Up&Go Test this visit due to: _____ _____		
Comments:		

<b>BLADDER/BOWEL:</b>		
1) In the past six months, have you accidentally leaked urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2) Do you have problems with loss of bowel control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments:		

<b>IMMUNIZATIONS:</b>		
1) Have you had a Flu shot within the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2) Have you had a Pneumonia shot?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3) Have you Had a Shingles shot?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4) When was your last Tetanus/Diphtheria Shot?	Date: _____	
Comments:		

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

<b>PREVENTATIVE SCREENINGS:</b>		
1) Have you had a Mammogram/Breast Cancer Screening (Women Only)? Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2) Have you had a Prostate Cancer Screening (Men Only)? Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3) Have you had a Colon Cancer Screening? Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4) Have you had a Cholesterol Screening? Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5) Have you had a Glaucoma Eye Screening? Date:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments:		

<b>HOME SAFETY:</b>		
1) Do you have trouble with stairs or have no stair rails inside or outside your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3) Does your home have working smoke alarms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments:		

<b>ACTIVITIES OF DAILY LIVING:</b>		
1) Do you get out of bed by yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2) Do you dress yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3) Do you make your own meals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4) Do you do your own shopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5) Do you bathe yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6) Do you do your laundry/housekeeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7) Do you manage your money, pay your bills and track your expenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Comments:		



Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE USE ONLY:**

Is there any decline in cognitive function or memory deficit through direct observation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, please indicate further evaluation and interventions planned:

**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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Comments:

**LIFESTYLE CHOICES:**

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

Comments:

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

<b>ADVANCED DIRECTIVES:</b>		
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2) Have you spoken to that person about your choices?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3) Have you completed a written Advance Directive, that is, a Living Will and/or Health Care Power of Attorney?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4) Do you have someone who helps you manage your healthcare, like a friend or family member?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

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

**\*\*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.**