ANNUAL WELLNESS VISIT

Patient Name (Last name first):____________________Date of Birth:______________

Today's Date: ______________________

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<td>We are pleased that you have scheduled your Medicare Annual Wellness Visit (AWV).To help make the most of your time with your physician or provider, please fill out these forms (FRONT AND BACK) in ADVANCE of your appointment and return them either by mail (allow 7 days if mailing) or in person at least 3 days before your appointment to:

YRMC PhysicianCare Wellness Clinic
7880 E. Florentine Rd.
Prescott Valley, AZ 86314-2216
928-772-2831

To protect your privacy, Do NOT email completed forms. 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 personal prevention plan.

Your Appointment Date/Time:_____________________</td>
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<td>**REMINDER – Be sure to include on this form:
A list of ALL your providers, including:
o Doctors – Primary Care & Specialists
o Nurse Practitioners or Physician Assistants
o Physical / Speech / Occupational Therapists
o Chiropractors
o ALL Pharmacies used – Name & Location
o ALL Medical Equipment companies used – Name & Location
**REMINDER – Please bring the following with you:
□ ALL medications, including:
o Over-the-counter medications, vitamins, supplements
o Ointments and Patches
o Eye Drops
□ Advance Directives/Living Wills-if not already on file</td>
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YAVAPAI REGIONAL MEDICAL CENTER PHYSICIAN care

ANNUAL WELLNESS VISIT QUESTIONNAIRE

PATIENT NAME:	DATE OF BIRTH:

Your answers on this form will help your health care provider to better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS IN THIS QUESTIONNAIRE WILL BE KEPT STRICTLY CONFIDENTIAL.

PROVIDER INFORMATION

Primary Care Provider: ______________________

PLEASE LIST ALL PROVIDERS THAT YOU HAVE CONSULTED WITH IN THE PAST 12 MONTHS

☐ Have not seen any providers other than primary care provider in the past 12 months

Name:	Name:
Specialty:	Specialty:
Street:	Street:
City:	City:
Phone:	Phone:
Name:	Name:
Specialty:	Specialty:
Street:	Street:
City:	City:
Phone:	Phone:

PLEASE LIST ALL AGENCIES (HOME HEALTH/HOSPICE/DURABLE MEDICAL EQUIPMENT PROVIDERS) THAT YOU ARE USING OR PREFER TO USE:

☐ No Home Health/Hospice/Durable Medical Equipment providers used / no preference if needed in future

Agency Name:	Agency Name:
Purpose:	Purpose:
Street:	Street:
City:	City:
Phone:	Phone:

PLEASE LIST SOCIAL SUPPORTS: FRIENDS OR FAMILY MEMBERS WHO HELP OR WOULD HELP (IF NEEDED) MANAGE YOUR HEALTH CARE:

☐ No social supports (no friends or family members available to help with health care)

Name:	Name:
Relationship:	Relationship:
Street:	Street:
City:	City:
Phone:	Phone:

☐ Include an attached list if you have additional providers of care

ALLERGIES

Please list all substances that you are allergic to (medications, food, bee sting, latex, etc.) and how each substance affects you

☐ NO KNOWN ALLERGIES

☐ NO KNOWN MEDICATION ALLERGIES

	Allergy Substance	Reaction	Severity (High, Medium, Low)	Age of Onset
1.				
2.				
3.				
4.				
5.				

Include an attached list if you have additional allergies

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ANNUAL WELLNESS VISIT QUESTIONNAIRE

PATIENT NAME:	DATE OF BIRTH:

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MEDICATION(S)

REMEMBER TO BRING ALL MEDICATION BOTTLES WITH YOU TO YOUR APPOINTMENT!

Please list all medication(s) you are taking. Include prescribed medications and all over-the-counter medications including vitamins and supplements

☐ **NO HOME MEDICATIONS**

	MEDICATION NAME	STRENGTH	FREQUENCY TAKEN	TAKING AS PRESCRIBED?
1.				☐ YES ☐ NO (explain)
2.				☐ YES ☐ NO (explain)
3.				☐ YES ☐ NO (explain)
4.				☐ YES ☐ NO (explain)
5.				☐ YES ☐ NO (explain)
6.				☐ YES ☐ NO (explain)
7.				☐ YES ☐ NO (explain)
8.				☐ YES ☐ NO (explain)
9.				☐ YES ☐ NO (explain)
10.				☐ YES ☐ NO (explain)

☐ **Include an attached list if you are taking additional medications**

NEW PROBLEM(S) IN THE PAST YEAR & PROBLEMS THAT HAVE RESOLVED IN LAST YEAR

Please write in any problems that have resolved in the last year or any NEW problems within the last year (include hospitalizations) :

☐ **NO CHANGES IN HEALTH HISTORY IN THE LAST YEAR**

	RESOLVED PROBLEMS:	DATE RESOLVED:	COMMENTS:		NEW PROBLEMS / HOSPITALIZATIONS	DATE OF ONSET/ HOSPITAL ADMISSION	DATE OF DISCHARGE (FOR HOSPITALIZATIONS)	COMMENTS:
1.				1.				
2.				2.				
3.				3.				
4.				4.				
5.				5.				
6.				6.				
7.				7.				
8.				8.				

☐ **Check if separate sheet is attached**

PROCEDURE HISTORY

Have you ever had a blood transfusion? ☐ YES ☐ NO

Have you ever had general anesthesia? ☐ YES ☐ NO If yes, did you experience any complications from it? ☐ YES ☐ NO

	PROCEDURE	MONTH/DATE/YEAR	PERFORMING LOCATION	PHYSICIAN
1.				
2.				
3.				
4.				

☐ **Include an attached list if you have had additional procedures**

MEDICAL DEVICES

☐ None
☐ Blood filtering, blocking device
☐ Contraception Device
☐ Heart Mechanical Device
☐ Implantable Cardioverter-defibrilator
☐ Implantable Pump
☐ Implants
☐ Insulin Pump
☐ Medication Pump
☐ Orthopedic Hardware/Pins
☐ Orthopedic Prosthesis
☐ Pacemaker
☐ Shrapnel
☐ Shunts
☐ Spinal Rods
☐ Stents
☐ Stimulator
☐ Other Metal in Body
☐ Other:

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ANNUAL WELLNESS VISIT QUESTIONNAIRE

PATIENT NAME:	DATE OF BIRTH:

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FAMILY HISTORY

Please check all that apply- include parents, grandparents, siblings, children: ☐ **Family history negative (no health problems)** ☐ **Family history unknown**

Use the following abbreviations:

Parents:

M: Mother	☐ **History negative (no health problems)**	☐ **History unknown**
F: Father	☐ **History negative (no health problems)**	☐ **History unknown**

Grandparents:

MGM: Maternal Grandmother	☐ **History negative (no health problems)**	☐ **History unknown**
MFG: Maternal Grandfather	☐ **History negative (no health problems)**	☐ **History unknown**
PGM: Paternal Grandmother	☐ **History negative (no health problems)**	☐ **History unknown**
PGF: Paternal Grandfather	☐ **History negative (no health problems)**	☐ **History unknown**
Siblings: Use first names	☐ **History negative (no health problems)**	☐ **History unknown**
Children: Use first names	☐ **History negative (no health problems)**	☐ **History unknown**

Disease	Parents	Grandparents	Siblings	Children
Abdominal aortic aneurysm				
Alcoholism				
Alzheimer's dementia				
Asthma				
Bleeding disorder				
COPD-Chronic obstructive pulmonary disease				
Cancer (list type of cancer)				
Clotting disorder				
Coronary artery disease				
Dementia				
Depression				
Drug abuse				
Fracture of hip				
Glaucoma				
Goiter				
Heart attack				
Hyperlipidemia				
Hypertension				
Hyperthyroidism				
Hypothyroidism				
Mental health disorder				
Migraine				
Osteoporosis				
Parkinson's disease				
Stroke				
TIA				
Thyroid disease				
Type 1 diabetes				
Type 2 diabetes				
Other:				

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ANNUAL WELLNESS VISIT QUESTIONNAIRE

PATIENT NAME:	DATE OF BIRTH:

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ADVANCE DIRECTIVE

Advance Directive: ☐ YES ☐ NO

Advance Directive Date:

Type of Advance Directive:
- ☐ Living will
- ☐ Medical durable power of attorney
- ☐ Blood product advance directive
- ☐ Other:

Medical Durable Power of Attorney Name & Contact Number:

Location of Advance Directive:
- ☐ Copy obtained from previous records
- ☐ Copy placed on paper chart
- ☐ Family to bring in copy from home
- ☐ Scanned into EMR
- ☐ Unable to obtain copy
- ☐ Other:

Surrogate Name & Contact Number:

Reason Copy Cannot Be Obtained:

HEALTH MAINTENANCE

Please place a check mark in the box(es) if you have had any of the following prevention measures:

Prevention measure	Date Performed	Performing Location
☐ Annual Wellness Visit	Date Performed:____/____/____	Performing Location:
☐ Tetanus Diptheria Pertussis (Tdap) Vaccine	Date Performed:____/____/____	Performing Location:
☐ Tetanus Diptheria (Td) Vaccine	Date Performed:____/____/____	Performing Location:
☐ Influenza Vaccine	Date Performed:____/____/____	Performing Location:
☐ Pneumococcal Conjugate Vaccine (Prevnar13)	Date Performed:____/____/____	Performing Location:
☐ Pneumococcal Polyvalent Vaccine (Pneumovax23)	Date Performed:____/____/____	Performing Location:
☐ Zoster (shingles) Vaccine (Zostavax)	Date Performed:____/____/____	Performing Location:
☐ Zoster (shingles) Vaccine (Shingrix #1)	Date Performed:____/____/____	Performing Location:
☐ Zoster (shingles) Vaccine (Shingrix #2)	Date Performed:____/____/____	Performing Location:
☐ Prostate Cancer Screening – PSA	Date Performed:____/____/____	Performing Location:
☐ Bone Density Screening (DEXA Scan)	Date Performed:____/____/____	Performing Location:
☐ Breast Cancer Screening (Mammogram)	Date Performed:____/____/____	Performing Location:
☐ Cervical Cancer Screening- PAP	Date Performed:____/____/____	Performing Location:
☐ Cervical Cancer Screening-HPV test	Date Performed:____/____/____	Performing Location:
☐ Cervical and Vaginal Cancer Screening-Pelvic exam	Date Performed:____/____/____	Performing Location:
☐ Colonoscopy (Colorectal Screening)	Date Performed:____/____/____	Performing Location:
☐ iFOB (stool test for occult blood)	Date Performed:____/____/____	Performing Location:
☐ Cologuard (sDNA) testing	Date Performed:____/____/____	Performing Location:
☐ Eye Exam (Diabetic Maintenance)	Date Performed:____/____/____	Performing Location:
☐ Foot Exam (Diabetic Maintenance	Date Performed:____/____/____	Performing Location:
☐ HgbA1C (Diabetic Maintenance)	Date Performed:____/____/____	Performing Location:
☐ Diabetes Screening (fasting glucose)	Date Performed:____/____/____	Performing Location:

PATIENT NAME (PLEASE PRINT)	**PARENT OR GUARDIAN NAME (PLEASE PRINT)**
PATIENT SIGNATURE	**PARENT OR GUARDIAN SIGNATURE**
DATE	**DATE**

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HEALTH RISK ASSESSMENT

Patient Name (Last name first):____________________Date of Birth:______________

General Health Assessment:	**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**
In general, would you say your health is:	☐	☐	☐	☐	☐
How would you describe the condition of your mouth and teeth- including false teeth or dentures?	☐	☐	☐	☐	☐

Compared to last year, how is your:	**Same**	**Better**	**Worse**
Physical Health?	☐	☐	☐
Eyesight?	☐	☐	☐
Hearing?	☐	☐	☐
Emotional Health?	☐	☐	☐

Social/Emotional Support Assessment:	**Always**	**Usually**	**Sometimes**	**Rarely**	**Never**
How often do you get the social and emotional support you need?	☐	☐	☐	☐	☐

Stress Level Assessment: **How often is stress a problem for you in handling such things as:**	**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
Your health?	☐	☐	☐	☐	☐
Your finances?	☐	☐	☐	☐	☐
Your family or social relationships?	☐	☐	☐	☐	☐
Your work? **N/A (retired):** ☐	☐	☐	☐	☐	☐

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HEALTH RISK ASSESSMENT

Patient Name (Last name first):____________________Date of Birth:______________

Anxiety Level Assessment: **In the past 2 weeks, how often:**	**Almost all of the time**	**Most of the time**	**Some of the time**	**Almost never**
Have you felt nervous, anxious, or on edge?	☐	☐	☐	☐
Were you NOT able to stop worrying or control your worrying?	☐	☐	☐	☐

Nutrition Assessment: Over the past 7 days, how many servings do you typically eat in each day?	**# of Servings typically eaten in a day:**
Fruits and vegetables? (1 serving= 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball)	
High fiber foods or whole grains? (1 serving=1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta)	
Fried or high-fat foods?	
Sugar-sweetened beverages?	
Sweets (desserts, snacks)?	
Caffeinated drinks?	
Non-caffeinated drinks/water?	

Orientation Assessment:	**Yes**	**No**
Are you having any confusion regarding date, time, place?	☐	☐
Do you get lost going back and forth from familiar places?	☐	☐

Concentration & Memory Assessment:	**Yes**	**No**
Are you having any problems concentrating?	☐	☐
Any memory lapses or forgetting recent events?	☐	☐
Are you forgetting words or the names of items or people?	☐	☐

HEALTH RISK ASSESSMENT

Patient Name (Last name first):____________________Date of Birth:______________

Speech/Motor Difficulties:	Yes	No
Are you having any speech difficulties or difficulties expressing yourself?	☐	☐
Are you having any problems writing or with fine motor coordination (dropping things, problems picking up small items such as paperclips)?	☐	☐

Vision Assessment:	Yes	No
Are you having any problems with loss of distant or near vision?	☐	☐
Are you having any problems with night vision or driving?	☐	☐

Hearing Assessment:	Yes	No
Do you have difficulty understanding speech with telephone calls?	☐	☐
Do you find it difficult to follow a conversation in a restaurant or crowded room?	☐	☐
Do you feel that people are not speaking clearly or mumbling?	☐	☐
Do you find yourself visiting less with friends & family due to difficulty hearing?	☐	☐
Have you had significant noise exposure during work, recreation or military service?	☐	☐

Bladder/Bowel Assessment:	Yes	No
In the last six months, have you accidentally leaked urine?	☐	☐
Do you have problems urinating?	☐	☐
Do you have problems with constipation?	☐	☐
Do you have problems with loss of bowel control?	☐	☐

Daily Activities Assessment:	Yes	No
Are you able to get out of bed by yourself?	☐	☐
Are you able to bathe and dress yourself?	☐	☐
Are you able to make your own meals?	☐	☐
Are you able to do your own shopping?	☐	☐
Are you able to do your own housekeeping and laundry?	☐	☐
Are you able to manage your money, track spending & pay bills?	☐	☐

HEALTH RISK ASSESSMENT

Patient Name (Last name first):____________________Date of Birth:______________

Daily Activities Assessment:	**Yes**	**No**
Are you able to take your medications as directed by your doctor?	☐	☐
Are you able to fall asleep at night and remain asleep?	☐	☐
How many hours of sleep do you usually get each night?		
Do you snore or has anyone told you that you snore?	☐	☐
Do you find yourself sleepy during the daytime?	☐	☐

Fall Risk Assessment:	**Yes**	**No**
Are you able to easily get up from a chair, walk 10 feet, turn around, walk back and sit down?	☐	☐
Are you afraid of falling?	☐	☐
Have you broken a bone in the past year?	☐	☐
Have you had any falls in the past year?	☐	☐
If yes: ☐ Only one fall without injury? ☐ One fall with injury? ☐ Two or more falls with or without injury?		

Exercise	**Yes**	**No**
Do you exercise for 20 minutes or more, three or more days each week?	☐	☐
If Yes, how intense is typical exercise? ☐ Light (Stretching or slow walking) ☐ Moderate (Brisk walking) ☐ Heavy (Jogging or swimming) ☐ Very heavy (Fast running or stair climbing)		

Home Safety:	**Yes**	**No**
Do you have any stairs or steps in your home?	☐	☐
If yes, do your stairs have railings? **N/A:** ☐	☐	☐
Do you have difficulty with stairs inside or outside of your home?	☐	☐
Do you have grab bars in your bathroom?	☐	☐
Does your home have working fire/smoke alarms?	☐	☐
Does your home have working carbon monoxide detectors?	☐	☐

HEALTH RISK ASSESSMENT

Patient Name (Last name first):______________________Date of Birth:________________

Home Safety:	**Yes**	**No**
Does your home have any loose floor rugs (small scatter rugs)?	☐	☐
Does your home have any areas with poor lighting?	☐	☐

Lifestyle Choices Assessment:	**Yes**	**No**
Do you currently drive a vehicle?	☐	☐
Do you always fasten your seat belt when you are in a vehicle?	☐	☐
Do you ever drive after drinking, or ride with a driver who has been drinking?	☐	☐
Tobacco use: Do you currently smoke or use tobacco?	☐	☐
If yes, would you be interested in quitting tobacco use within the next month? **N/A:** ☐	☐	☐
Alcohol use/Single-item Alcohol screening question: Do you sometimes drink beer, wine, or other alcoholic beverages?	☐	☐
If yes:	Number:	
How many drinks per day?		
How many drinks per week?		
How many times in the past year have you had: Men under age 65: 5 or more drinks in 1 day? Women and everyone age 65 and older: 4 or more drinks in 1 day?		

Patient Signature:	Date:
For office use below.	
Reviewed by:	Date:
Physician Signature(reviewed with patient and reconciled with chart at visit):	Date:

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