COMMUNITY MEDICAL CENTER | COMMUNITY PHYSICIAN GROUP

Annual Wellness Visit
Intake Form

Name: _____ Age:_____ Date:_____

Specialty Providers: _____

Do you have an advanced directive? _____

Preferred Pharmacy: _____

Medication Allergies: _____

Medications:
List Prescription and over the counter medications, vitamins, and supplements you are currently taking.

Medication Name	Dose	Frequency

Preventive Medicine:
Please provide the last date and location (if applicable) of your:

***Vaccines*:**

Tetanus_____

Pneumococcal_____

Influenza _____

Shingles_____

Colonoscopy_____

Bone Density Scan_____

Mammogram_____

PAP Smear_____

Screening Chest CT (lung cancer) _____

Health Risk Assessment
Please answer the following questions for your wellness visit today:

1. What is your age?
   ☐ 18-64 ☐ 65-69 ☐ 70-79 ☐ 80 or older
2. Are you a male or a female?
   ☐ Male ☐ Female
3. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?
   ☐ Not at all
   ☐ Slightly
   ☐ Moderately
   ☐ Quite a bit
   ☐ Extremely
4. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?
   ☐ Not at all.
   ☐ Slightly.
   ☐ Moderately.
   ☐ Quite a bit.
   ☐ Extremely.
5. During the **past four weeks**, how much bodily pain have you generally had?
   ☐ No pain.
   ☐ Very mild pain.
   ☐ Mild pain.
   ☐ Moderate pain.
   ☐ Severe pain.
6. During the **past four weeks**, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)
   ☐ Yes, as much as I wanted.
   ☐ Yes, quite a bit.
   ☐ Yes, some.
   ☐ Yes, a little.
   ☐ No, not at all.
7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?
   ☐ Very heavy.
   ☐ Heavy.
   ☐ Moderate.
   ☐ Light.
   ☐ Very light.
8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)
   ☐ Yes ☐ No.
9. Can you go shopping for groceries or clothes without someone's help?
   ☐ Yes ☐ No.
10. Can you prepare your own meals?
    ☐ Yes ☐ No.
11. Can you do your housework without help?
    ☐ Yes ☐ No.
12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
    ☐ Yes ☐ No.
13. Can you handle your own money without help?
    ☐ Yes ☐ No.
14. During the **past four weeks**, how would you rate your health in general?
    ☐ Excellent.
    ☐ Very good.
    ☐ Good.
    ☐ Fair

15. How have things been going for you during the **past four weeks**?

☐ Very well; could hardly be better.

☐ Pretty well.

☐ Good and bad parts about equal.

☐ Pretty bad.

☐ Very bad; could hardly be worse.

16. Are you having difficulties driving your car?

☐ Yes, often.

☐ Sometimes.

☐ No.

☐ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

☐ Yes, usually.

☐ Yes, sometimes.

☐ No.

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	☐	☐	☐	☐	☐
Sexual problems.	☐	☐	☐	☐	☐
Trouble eating well.	☐	☐	☐	☐	☐
Teeth or denture problems.	☐	☐	☐	☐	☐
Problems using the telephone.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

19. Have you fallen two or more times in **the past year**?

☐ Yes ☐ No.

20. Are you afraid of falling?

☐ Yes ☐ No.

21. Are you a smoker?

☐ No.

☐ Yes, and I might quit.

☐ Yes, but I'm not ready to quit.

22. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

☐ 10 or more drinks per week.

☐ 6-9 drinks per week.

☐ 2-5 drinks per week.

☐ One drink or less per week.

☐ No alcohol at all.

23. Do you exercise for about 20 minutes three or more days a week?

☐ Yes, most of the time.

☐ Yes, some of the time.

☐ No, I usually do not exercise this much.

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes ☐ No.

Keeping track of your medications?

☐ Yes ☐ No.

25. How often do you have trouble taking medicines the way you have been told to take them?

☐ I do not have to take medicine.

☐ I always take them as prescribed.

☐ Sometimes I take them as prescribed.

☐ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?

☐ Very confident.

☐ Somewhat confident.

☐ Not very confident.

☐ I do not have any health problems.

27. What is your race? (**Check all that apply.**)

☐ White.

☐ Black or African American.

☐ Asian.

☐ Native Hawaiian or other Pacific Islander.

☐ American Indian or Alaskan Native.

☐ Hispanic or Latino origin or descent.

☐ Other

Thank you very much for completed your annual wellness form. Please bring this completed form to your appointment.