ANNUAL WELLNESS VISIT TODAY'S DATE:_____

Patient name				Date of birth	AGE	Gender
BP	HR	RR	HT	LMP	Weight	TEMP

SOCIAL HISTORY

TOBACCO USE (CIRCLE ONE) Never Current Smoker No of years _____ Packs per day_____ Quit Year_____ Other Tobacco

ALCHOL USE (CIRCLE ONE) Never Few Times/Year 1-2 Drinks per day 3 or more per day Past History of abuse_____year quit

HOME ENVIRONMENT	Private home	Assisted Living	Nursing Home	Allergies

FUNCTIONAL / SAFETY SCREEN (*65 AND OVER*)

Do you need someone else to drive for you?	Yes	No	Do you have any difficulty feeding yourself?	Yes	No
Do have difficulty with mobility? (getting out of bed, walking, or getting in/out of a chair)	Yes	No	Do you have difficulty getting dressed?	Yes	No
Do you have difficulty with grooming? (combing hair, shaving, brushing teeth)	Yes	No	Do you need help with your shopping?	Yes	No
Do you need help with housekeeping?	Yes	No	Do you need help managing your money?	Yes	No
Do you need help managing your medications?	Yes	No	Do you need help using the telephone?	Yes	No
Do you have stairs in your home without handrails or with poor lighting?	Yes	No	Do you have difficulty with balance?	Yes	No
Have you noticed any hearing difficulties?	Yes	No	Does your bladder sometimes leak?	Yes	No
Have you felt down, depressed or hopeless **during the past 2 weeks**	Yes	No			
Have you had days where you felt very little pleasure in activities **during the past two weeks**	Yes	No			
Do you have a living will or advanced directive?	Yes	No			

Do you have regular or frequent pain?	None	Mild	Moderate or occasional	Continuous	Severe

Have you fallen DURING THE LAST 12 MONTHS?	No	Only once, no injury	Two or more times	Injury that required medical attention

	YEAR		*YEAR*		*YEAR*
Influenza (Flu Shot)		Pneumovax 23 (Pneumonia)		Tetanus / pertussis (TDaP)	
Shingles		Prevnar 13 (Pneumonia)		Tetanus / NO pertussis (dT)	
Hepatitis A		Hepatitis B		Gardasil	

ANY RECENT SURGERIES/HOSPITAL STAYS

Hospital visits / Reason	**Facility**	**Attending Physician**	**Dates**	

PROVIDER LIST (Please list all used /seen during past year)

Physicians	**Reason**	**Other Physician / Therapist / Chiropractor**	**Reason**

Local Pharmacy/Phone Number	Mail Order Pharmacy	Prescription Insurance Name
Name of Medication/How often *Example: Ibuprofen:1 daily*	**Medication/ How Often**	**Medication/How often**

Screening Done	Date	Screening	Date	Screening	Date
Colonoscopy		**Stool Test Blood**		**Pap/Pelvic Exam**	
Mammogram		**Bone Density**		**Prostate**	
Eye /glaucoma		**Hearing**		**Abdominal US**	

During the *past 2 weeks*, have you had any of the following symptoms? *(Mark all that apply.)*

	General		GASTROINTESTINAL		NEUROLOGICAL
	Fever/Chills		Abdominal Pain		Headaches
	Sweats		Nausea or Vomiting		Dizziness/Lightheaded
	Unexplained Weight Loss/gain		Heartburn		Weakness of Face, Arm, Leg
	Weakness or fatigue		Difficulty or pain swallowing		Numbness or Tingling
	HEENT		Diarrhea		Memory Loss
	Change in Vision		Constipation		Problems with Balance/Coordination
	Eye Pain		Blood in bowel Movement		**PSYCHIATRIC**
	Difficulty Hearing		**GENITAL/URINARY**		Anxiety/Stress
	Ringing in Ears		Urination more than 2x a night		Depression or Feeling Down
	Problem with Teeth		Leaking Urine		Problems with Sleep
	Hay Fever/Allergies		Difficulty Emptying Bladder		**BLOOD/LYMPHATIC**
	Sore Throat		Blood In Urine		Unexplained Bruises
	CARDIOVASCULAR		Unusual Vaginal Bleeding		Unexpected/Easy Bleeding
	Chest Pain		Difficulty with Sexual Function		**ENDOCRINE**
	Heart Racing or Skipping		Discharge from Penis or vagina		Excessive Thirst or Urination
	Swelling		**MUSCLES/JOINTS**		Hot Flashes or Night Sweats
	RESPIRATORY		Muscle Pain or Cramps		Intolerance to Heat or Cold
	Cough		Joint Pains		
	Wheezing		Neck or Back Pain		
	Difficulty Breathing		**SKIN**		
	BREASTS		Rashes or Skin Lesions		
	Lump, Tenderness in Breast		Changed or Worrisome Moles		
	Discharge from Nipple				

CHANGES IN FAMILY HISTORY	FATHER	MOTHER	BROTHER	SISTER	CHILD

_____

Patient Signature

******FOR YOUR SAFETY, WE DO NOT ACCEPT REFILL REQUEST FROM PHARMACIES.***

REFILLS MUST BE REQUESTED BY THE PATIENT.***