Annual Wellness Visit

Patient Name:

Date of Birth:

Appointment Provider:

Health Maintenance

Test	Recommendation	Date done
Colorectal Cancer Screening	Age 50 - 75 every 10 years	
Cervical Cancer Screening	Women Aged 21 to 65 years	
Prostate cancer screening	Males Age 45 to 49 base line test__Age 50 and older annually	
HIV Screening	Annually for patients ages 15–65	
Influenza Vaccine (Flu)	Annually	
Pneumococcal Vaccine	Ages 65 and older	
TDaP Vaccine	Once every ten years	
Retina eye exam	Annually for individuals with Diabetes II__Adults 65 and older	
Mammogram	Females every 2 years ages 50-74	
Bone Density Screening	Women 65 years and older or younger who are post menopausal_Men 70 years and older	

General Health Rating

Overall health:	[ ] Excellent [ ] Very good [ ] Good [ ] Fair [ ] Poor
Physical health:	[ ] Much better [ ] Slightly better [ ] Same [ ] Worse
Eyesight:	[ ] Same [ ] Slightly worse [ ] Much worse
Hearing:	[ ] Same [ ] Slightly worse [ ] Much worse
Emotional/mental health:	[ ] Much better [ ] Slightly better [ ] Same [ ] Worse
Pain scale last 7 days:	0 1 2 3 4 5 6 7 8 9 10
Nutritional health:	[ ] Excellent [ ] Very good [ ] Good [ ] Fair [ ] Poor

Functionality-safety assessment

Do you have difficulty or require assisstance with the following?

Bathing	[ ] Yes [ ] No	Grocery Shopping	[ ] Yes [ ] No
Dressing	[ ] Yes [ ] No	Driving	[ ] Yes [ ] No
Toileting	[ ] Yes [ ] No	House keeping	[ ] Yes [ ] No
Grooming	[ ] Yes [ ] No	Taking medication	[ ] Yes [ ] No
Cooking	[ ] Yes [ ] No	Climbing stairs	[ ] Yes [ ] No

Hearing loss assessment	
Do you have hearing aids?	[ ] Yes [ ] No
Do you have problems hearing over the telephone?	[ ] Yes [ ] No
Do people complain that you turn the TV or radio volume to high?	[ ] Yes [ ] No
Do you have trouble hearing in a noisy background?	[ ] Yes [ ] No
Do you find yourself asking people to repeat themselves?	[ ] Yes [ ] No
Do you misunderstand what others are saying to you?	[ ] Yes [ ] No
Do you experience ringing or noises in your ears?	[ ] Yes [ ] No
Have you had any significant noise exposure during any events?	[ ] Yes [ ] No

Cognitive assessment	
Problems with Judgements? (Bad financial or personal decisions)	[ ] Yes [ ] No
Less interest in hobbies/activities?	[ ] Yes [ ] No
Trouble learning how to use a tool, appliance or gadget?	[ ] Yes [ ] No
Forget the correct month or year?	[ ] Yes [ ] No
Struggle with handling financial affairs?	[ ] Yes [ ] No
Trouble remembering appointments?	[ ] Yes [ ] No
Daily problems with thinking and or memory?	[ ] Yes [ ] No

Fall Risk Assesment	
I have Fallen in the last 6 months	[ ] Yes [ ] No
I use or have been advised to use a cane or walker	[ ] Yes [ ] No
Sometimes I feel unsteady when I am walking	[ ] Yes [ ] No
I steady myself by holding onto furniture when I walk	[ ] Yes [ ] No
I am worried about falling	[ ] Yes [ ] No

Maltreatment	
Have you relied on people for any of the following: Bething, dressing, shopping, banking or meals?	[ ] Yes [ ] No
Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	[ ] Yes [ ] No
Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	[ ] Yes [ ] No
Has anyone tried to force you to sign papers or to use your money against your will?	[ ] Yes [ ] No
Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	[ ] Yes [ ] No

Advance Care Planning

Choose your Health Care Agent to make medical decision on your behalf

First Choice Name:	2nd Choice Name:
Relationship:	Relationship:

Responsibility you want your Health Care Agent to make		
Medical care and services, like medications, procedures and surgery	[ ] Yes	[ ] No
Admission to assisted living facility, nursing home and palliative care	[ ] Yes	[ ] No
Access and approval to release my medical or personal files	[ ] Yes	[ ] No
Interpret instructions given in this form according to my wishes and values	[ ] Yes	[ ] No

What your Health Care Agent should keep in mind		
My personal, cultural and spiritual beliefs upon medical decision making	[ ] Yes	[ ] No
I would like to donate any viable organs or tissues up on my death	[ ] Yes	[ ] No
I want medications to be used for pain, depression, nausea etc	[ ] Yes	[ ] No
Apply for any insurance benefits or programs necessary needed for my care	[ ] Yes	[ ] No

Life support treatment options		
If you are expected to die with in a short period of time	[ ] Yes	[ ] No
If you are in a coma and not expected to wake or recover	[ ] Yes	[ ] No
If you have permananent and severe brain damage	[ ] Yes	[ ] No
Would you like to have a do not resuscitate order with expected death	[ ] Yes	[ ] No

Post death requests		
My wish and values to be respected even if they are not agreed with	[ ] Yes	[ ] No
I would like my body to buried after my death	[ ] Yes	[ ] No
I would like my body to be cremated after my death	[ ] Yes	[ ] No
Do you have another option in mind for your body after your death	[ ] Yes	[ ] No

Important Notice

This review of your Advance Care Planning is for discussion purposes only and has no legal effect on your decisions. Should you want to make any binding decisions, please consult your lawyer.