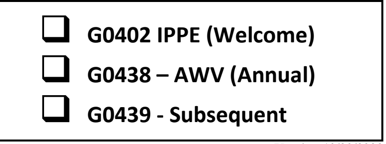

Version 10/30/2023

ANNUAL WELLNESS VISIT *(annual chief complaint)*

Office staff: Medical Record Number: ________________________________ *Date of Service*__________________

PLEASE PRINT:

Patient Name ____

Date of Birth _________________________ Gender ☐Male ☐Female

Race *(ex: Caucasian, Asian)* ______________ Ethnicity *(ex: Italian, German)* _________________

Medicare B Eligibility Date ____________________

PAIN *(office: EPIC's vital signs – pain information)*

⇨Please circle your answers

How often is pain a problem for you?	Never	Sometimes	Often	Always

Where is your pain? ____

Circle one of the faces below that best relates to your pain:

0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

(Office: complete EPIC's hearing (simple screen)/vision, timed up and go)

ALLERGIES - Please list all allergies or reactions to medications *(office: EPIC's allergies)*

Allergy/Medication(s):	**Reaction:**
☐ No Allergies	
☐ **No Changes in the last year**	

MEDICATIONS - Please list all medication you currently take including prescriptions, supplements, cold medication, aspirin, vitamins, and birth control pills. Please list all medication dosages and frequency taken. *(office: EPIC's medications)*

Medication	Dosage	Frequency
☐ I take NO Medications		
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________
______________________	__________	______________________

MEDICAL HISTORY - List all illnesses and injuries & when they started. (For example: asthma, diabetes, high blood pressure, heart murmur, epilepsy, cancer, depression, fatigue, accidents, fractures, head injuries, burns) *(Office: EPIC's medical history section & update problem list)*

Problem(s):	
☐ **No Changes in Medical History in the last year**	**Date**
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

HOSPITALIZATIONS- other than for surgeries *(Office: EPIC's medical/surgical history section)*

Hospitalized for:	
☐ Never been hospitalized	
☐ **No Hospitalizations in the last year**	**Date**
______________________________	______________
______________________________	______________
______________________________	______________

<u>SURGICAL HISTORY</u> -- List all surgeries & the date of surgery. *(For example: tonsillectomy, appendix, gallbladder, hernia, hysterectomy)* *(Office: EPIC's surgical history section)*

<u>Surgery for</u> **<u>Date</u>**

☐ No Surgeries

☐ **No new Surgeries in the last year**

____ ______________

____ ______________

____ ______________

____ ______________

____ ______________

____ ______________

<u>FAMILY HISTORY for blood relatives</u> *(Office: EPIC's family history section)*

Mother's age now ______ (or age at death) _____

Father's age now _______ (or age at death) _____

☐ **No Family History changes in the past year**

Has any immediate family member *(parents, brother, sister, grandparents, and children)* had:

Yes	No		Which Family Member(s) / What Age:
☐	☐	Alcoholism	______________________________
☐	☐	Asthma	______________________________
☐	☐	Cancer	______________________________
☐	☐	Depression	______________________________
☐	☐	Diabetes	______________________________
☐	☐	Drug Problem	______________________________
☐	☐	Heart attack	______________________________
☐	☐	High Blood Pressure	______________________________
☐	☐	High Cholesterol	______________________________
☐	☐	Stroke	______________________________
☐	☐	Other illness or conditions that run in your family	______________________________

SOCIAL HISTORY *(Office: EPIC's social history and EPIC's Social Determinants section)*

Yes No

☐ ☐ Do you drink alcohol?

☐ ☐ If YES to drinks alcohol above, is it more than 4 drinks in 1 day or 28 in a week?
How many drinks per week? ___________________________
(If Yes to more than 4 alcoholic drinks per day or 28 per week, perform AUDIT flowsheet.)

☐ ☐ Have you used illegal drugs? Which ones: _____________________________
(If Yes to illegal drug use, perform DAST flowsheet)

☐ ☐ Do you smoke?
If yes, what type/ amount? ____________________________________
(Office: If Yes to smoking, give Smoking Cessation Counseling)

☐ ☐ Are you currently taking Opioid (pain) medication?

☐ ☐ Have you ever been hospitalized and/or treated for opioid overuse?

☐ ☐ In the last 12 months, were you unable to pay your mortgage or rent on time?

☐ ☐ In the last 12 months, was there a time you did not have a steady place to sleep or slept in a shelter (including now)?

☐ ☐ In the last 12 months, has lack of transportation kept you from medical appointments or getting access to medications?

☐ ☐ In the last 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?

☐ ☐ Within the past 12 months, were you worried that your food would run out before you had money to buy more? If yes, were you sometimes worried or often worried? ______________

☐ ☐ Within the past 12 months, the food you bought just didn't last and you didn't have money to buy more. If yes, were you sometimes worried or often worried? ______________

➪***Please circle your answers***

What is your Marital Status?	Single	Married	Widowed	Separated
What is your Occupation?	Retired Y / N	If Employed Occupation:		

What was your highest level of education?_________

What are your hobbies? ____

Women Only: GYNECOLOGICAL HISTORY *(Office: EPIC's obstetric history section)*

Number of pregnancies	______________	Number of miscarriages	____________
Number of children	______________	Number of abortions	____________

Activities of Daily Living, *Part 1 of 2* *(Office: EPIC's ADL's section)*

Back Care?	Yes	No	Gun Owner?	Yes	No	Sleep Concern?	Yes	No
Bike Helmet?	Yes	No	Hobby Hazards?	Yes	No	Smoke Detectors?	Yes	No
Blood Transfusions?	Yes	No	Military Service?	Yes	No	Special Diet?	Yes	No
Body Piercings?	Yes	No	Occupational Exposure?	Yes	No	Stress Concern?	Yes	No
Caffeine Concern?	Yes	No	Seat Belt?	Yes	No	Tattoos?	Yes	No
Exercise?	Yes	No	Self-Exams?	Yes	No	Weight Concern?	Yes	No

☐ **No changes to Activities of Daily Living in the past year.**

DEPRESSION SCREEN *(Office: PHQ 9 added, are there any office notes we need to add here?)*

Yes	No	
☐	☐	Over the past two weeks, have you felt little interest or pleasure in doing things?
☐	☐	Over the past two weeks, have you felt down, depressed, or hopeless?
☐	☐	Trouble falling or staying asleep, or sleeping too much?
☐	☐	Feeling tired or having little energy?
☐	☐	Poor appetite or overeating?
☐	☐	Feeling bad about yourself – or that you are a failure or have let your family down?
☐	☐	Trouble concentrating on things, such as reading the newspaper or watching television?
☐	☐	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?
☐	☐	Thoughts that you would better off dead or hurting yourself in some way?
☐	☐	How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

ACTIVITIES OF DAILY LIVING, *Part 2 of 2*

(Office: For next 2 pages, use PNA Annual Wellness Visit Flowsheet) *(Provider: if needed, consider a Referral)*

Yes	No	
☐	☐	Do you have a well-balanced diet? If no, why not? ________________________
☐	☐	How often do you exercise?____________ ____what type? ________________
☐	☐	Do you drive? If not, who provides transportation?__________________
☐	☐	Are you able to get on and off the toilet easily?
☐	☐	Do you have self-control over your bladder or bowel?
☐	☐	Do you need help with eating or meal preparation?
☐	☐	Do you need help shopping or doing light housekeeping?
☐	☐	Do you have difficulty doing errands alone?
☐	☐	Do you need help with dressing/bathing?
☐	☐	Do you have a problem functioning sexually?
☐	☐	Do you have any trouble hearing?
☐	☐	Do you have any trouble seeing, even with glasses?
☐	☐	How many hours can you be left alone? __________

COGNITIVE / FUNCTIONAL STATUS *(Provider: if needed, consider Referral)*

Yes	No	
☐	☐	Are you having trouble concentrating or making your own decisions?
☐	☐	Do you have trouble managing the mail or paying bills?
☐	☐	Are you having trouble ordering your medication or scheduling doctors appts?
☐	☐	Are you having trouble remembering to take your medications?
☐	☐	Do you have a decreased sense of direction?
☐	☐	During the past year, have you experienced confusion or memory loss that is happening more often or getting worse?

GENERAL LIFE SATISFACTION: *(Provider: if needed, consider a Referral or further testing)*

⇨Please circle your answers

How often do you get the social and emotional support you need?	Always	Usually	Some-times	Rarely	Never
During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors or groups?	Always	Usually	Some-times	Rarely	Never
During the past four weeks, was someone available to help you if you needed or wanted it?	Always	Usually	Some-times	Rarely	Never

⇨Please circle your answers

In general, how satisfied are you with your life:	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
How often is stress a problem for you?	Never	Some-times	Often	Always

SAFETY SCREEN *(If Yes for the fall questions (1&2), complete STEADI Fall Risk in Visit Navigator)*

Yes	No	
☐	☐	*How many times have you fallen in the last Year?_______*
☐	☐	*Do you worry about falling?*
☐	☐	Has anyone made you afraid or hurt you physically?
☐	☐	Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
☐	☐	Has anyone tried to force you to sign papers or to use your money against your will?

Adult Activity Level - *For activity to be regular, it must add up to a total of 30 minutes or more per day and be done at least 5 days per week.* (Please mark 1 answer)

☐1	I currently do NOT exercise and do not intend to start exercising in the next 6 months.
☐2	I currently do NOT exercise, but am thinking about starting in the next 6 months.
☐3	I currently exercise some, but not regularly.
☐4	I currently exercise regularly, but I have only begun to do so in the last 6 months.
☐5	I currently exercise regularly, and have done so for longer than 6 months.

Do you receive health care from other physicians or sources?

(Office: add physicians to EPIC's care team, patient care team section, team member)

YES	NO	Specialty	Provider Name	Reason for Visit?	Last Visit Date?
☐	☐	Audiologist (Hearing)			
☐	☐	Cardiologist (Heart)			
☐	☐	Dermatologist			
☐	☐	Dentist			
☐	☐	Gastrointestinal (GI)			
☐	☐	Optometrist (Eye)			
☐	☐	Podiatrist (Feet)			
☐	☐	Medical Equipment			
☐	☐	Home Health			
Other:					

☐ **No new Physicians/Providers seen in the last year.**

Health Maintenance *(Office: update EPIC's health maintenance section)*

- **Immunizations** **Date Last Done**

Immunization	Date Last Done
Last tetanus shot	_____________
Pneumonia vaccine #1	_____________
Pneumonia vaccine #2	_____________
Last flu shot	_____________
Hepatitis B Series	_____________
Covid vaccine	_____________
RSV	_____________
Zostavax	_____________
Shingrix	_____________

- **Preventive Screenings** **Date last done:**

Screening	Date last done:	
DEXA	____________	
Colonoscopy	____________	
Eye exam	____________	
FOBT (Fecal Occult Blood Test)	____________	
Hep C (if born 1945-1965)	____________	
Mammography	____________	
Lung Nodule Screening	____________	
Cardiovascular Disease	____________	
HIV Screening	____________	
Abdominal Aortic Aneurysm	____________	
Pap smear	____________	(Female only)
PSA	____________	(Male only)

YES	NO	
☐	☐	**Do you have a POLST or Advanced Care Directive?** *(Office: EPIC's Directives section)*

Who would be able to help you in case of illness or emergency?

Name: ____

Relationship: ___________________________________

Phone #: _______________________

- Please sign here for your approval to send your healthcare information to the person listed above:____*(your signature)*

This form was filled out by (please print your name):

Name: ____
Relationship? ___________________________________

Staff Signature ___________________________________
Staff member conducting initial intake: _________________________ Date:___________

(*Office: HCC evaluation of conditions in the Problem's List and provide a DSP for each.)*
Provider Signature _________________________________
Review/notation of
pertinent history performed: ________________________________Date:_____________