Annual Wellness Exam

Today's Date_____

Patient Name_____ Date of Birth_____

- Where do you live? ☐ private residence ☐ assisted living facility
- If applicable, please list other doctors currently treating you:
  _____
- Are you unsteady or have difficulty rising from a sitting position? ☐ **YES** ☐ **NO**
- Do you currently need help with phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? ☐ **YES** ☐ **NO**
- Does your home have any of the following:
  Rugs in the hallway ☐ **YES** ☐ **NO** Grab bars in the bathroom ☐ **YES** ☐ **NO**

  Handrails on the stairs ☐ **YES** ☐ **NO** ☐ **N/A** Poor lighting ☐ **YES** ☐ **NO**
- Have you had difficulty hearing? ☐ **YES** ☐ **NO**
- Regarding Advanced Care Planning, do you have a:
  ☐ LIVING WILL ☐ POWER OF ATTORNEY (FINANCIAL AND/OR MEDICAL)

  ☐ DO NOT RESUSCITATE ORDER
- Are you currently seeing an ophthalmologist/optometrist? ☐ **YES** ☐ **NO**
- Have you had a vision exam over the last 12 months? ☐ **YES** ☐ **NO**
- If applicable, please indicate the year you received the following immunizations:

Flu_____Pneumonia_____Tetanus_____Zostavax (Shingles)_____

- Have you smoked 100 cigarettes or more during your lifetime? ☐ **YES** ☐ **NO**
- Where applicable, please indicate the month and year you last had a(n):
  Colonoscopy _____
  Mammogram _____
  DEXA scan (osteoporosis screening) _____
  Ultrasound of Aorta (to rule out aneurysm)_____

Do you exercise regularly? ☐ **YES** ☐ **NO**

Do you have a healthy diet? ☐ **YES** ☐ **NO**

Patient Name_____ **Date of Birth**_____

Please Check Any Of The Following Symptoms That *Currently* or *Recently* Apply To You.

Respiratory

- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Chest Congestion
- ☐ Cough

Cardiac

- ☐ Dizziness
- ☐ Chest Pain
- ☐ Fast Heart Rate
- ☐ Leg Edema

Constitutional

- ☐ Night Sweats
- ☐ Heat Intolerance
- ☐ Heat Intolerance
- ☐ Fever
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Loss of Appetite
- ☐ Fatigue

Skin

- ☐ Rash
- ☐ Mole
- ☐ Lumps
- ☐ Hives

Psychiatry

- ☐ Depression
- ☐ Suicidal Ideation
- ☐ Abuse Mental or Physical

☐ Seasonal Allergies

Ophthalmology

- ☐ Diminished Vision
- ☐ Eye Irritation
- ☐ Blurring of Vision

ENT

- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Cough
- ☐ Sore Throat

Gynecology

Have you ever had an abnormal mammogram?

☐ Yes ☐ No

If yes, when? _____

Date of last mammogram:

_____

- ☐ Heavy/Abnormal Periods
- ☐ Infertility
- ☐ Pelvic Pain
- ☐ Breast Pain/Mass
- ☐ Hot Flashes

Male Reproduction

- ☐ Difficulty with Erection
- ☐ Diminished Sex Drive

Gastroenterology

- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stool

Blood Disorders

- ☐ Anemia
- ☐ Swollen Glands
- ☐ Easy Bruising

Musculoskeletal

- ☐ Joint Stiffness
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Sciatica

Neurology

- ☐ Migraine Headache
- ☐ Tension Headache
- ☐ Numbness
- ☐ Seizures
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Dizziness

Urology

- ☐ Difficulty Urinating
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Urinary Incontinence
- ☐ Voiding Dysfunction

Endocrine

- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Osteoporosis

PHQ-9 Patient Questionnaire

Nine symptom checklist

Patient Name: _____ Date: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
3. Trouble falling/staying asleep, sleeping too much.	☐	☐	☐	☐
4. Feeling tired or having little energy.	☐	☐	☐	☐
5. Poor appetite or overeating.	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
8. 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.	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

---

10. If you checked off any problem on this questionnaire so far, 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?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult