Annual Wellness Visit, Including Personalized Prevention Plan Service

Patient _____ Chart:_____ Date: _____
List of current doctors:
_____ Last seen: _____
_____ Last seen: _____
_____ Last seen: _____
You get your medical supplies from: _____
Mobility:
Do you have steady gait? Yes ____ No ____+
Do you walk with assistance? Yes ____ No_____ Use of cane, walker, wheelchair, motor chair
Are you able to do activities of daily living (ADL)? Yes____ No____
Do you handle your own money? Yes ____ No____
Is your home safe: good lighting, hand rail on stairs & bath tubs? Yes ___ No___

Lifestyle:
Physical activity: Active _____ Sedentary _____ Comments _____
Diet: Regular ____ Diabetic ____ Low Salt ____ Low Fat ____ Comments
_____
Depression:
Are you depressed? Yes ___ No___ Do you take medication for depression? Yes___ No___

Functionality:
Do you have any problems hearing? Yes___ No___ Do you want us to help? Yes ____ No_____
Do you have any problem with vision? Yes___ No___ Last eye exam date ? _____
Do you have annual eye exam? Yes ____ No ____ (Necessary if you are a diabetic) Date_____
Vaccinations:
Have you had Pneumonia vaccine? Yes___ No ___ (given only once after 65) Date: _____
Do you want a Pneumonia Vaccine? Yes___ No___
Have you had a Flu vaccine? Yes___ No___ Date: _____ Do you want one? Yes___ No___
Have you had a Shingles vaccine? Yes___ No___ Date: _____ Do you want one? Yes___ No___
Have you had a Tetanus shot? Yes___ No___ Date:_____ Do you want one? Yes ____ No____

Have you had a Colonoscopy? Yes___ No___ Date:_____
Do you want us to set up? Yes___No___ (needed every 5-10 years)

Prostate exam + PSA (males)_____(yearly)? Do you want us to set up? Yes___ No___
(Needed yearly until age 75)

Last mammogram (females)_____ . Do you want us to set up? Yes___No___
(Needed annually until age 40 then bi-annual for age 50-70)

Late Pap smear _____. Do you want us to set up? Yes___ No___
(Needed every 3 years)

Have you had a Bone Density? Yes___No___ Date:_____ Do you want us to set up? Yes__
No__

Risk factor profile
Do you smoke? Yes___ No___
Do you use alcohol? Yes___ No___
Are you over weight? Yes___ No___

Your ideal weight should be _____
Do you have trouble controlling you Bowel/Bladder? Yes___ No___

Financial: Good _____ Difficult_____
Comments_____
Support system: Good _____ Poor _____ Comments _____
Transportation: Self___ Family/Friends _____ SNF/AL_____
Medication Management: Self___ Family/Friends _____ SNF/AL_____
Do you have a living will/Medical Directive/Power Attorney? Yes___ No___
Who do you want to make health care decisions if you are unable to do it yourself?

Do you want CPR if you heart stops? Yes___ No___
Do you want to be hooked up to a ventilator if your breathing stops? Yes ___ No___
Do you want to be on life support if you have a terminal illness or dementia? Yes___ No___

Does patient need HIV Screening? Yes___ No___
Does patient need Cardiovascular Screening? Yes___ No___
Does patient need counseling to prevent tobacco use? Yes___ No___
Does patient need Diabetic Self Maintenance training? Yes___ No___
Does patient need Medical Nutritional Training? Yes___ No _____
Privacy Policy: Family members name's you would like for Dr. Saeed to release medical information too:

Depression scale: #_____

Fall Risk Screening

Assess one point for each core element "yes":

Diagnoses (3 or more coexisting)	_____
Prior History of falls within 3 months	_____
Incontinence	_____
Visual Impairment	_____
Impaired functional mobility	_____
Environmental hazards	_____
Polypharmacy (4 or more prescriptions)	_____
Pain affecting level of function	_____
Cognitive impairment	_____

Total—
A score of 4 or more is considered at risk

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Reviewed past medical and surgical history, including experiences with illnesses, hospital stays operations, allergies, injuries, and treatments. ☐

Reviewed use of or exposure to medication and supplement. ☐

the last 2 weeks, how often have you been bothered any of the following problems? (Circle)

	NOT AT ALL	SEVERAL DAYS	OVER HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things (reading, watching television, etc.)	0	1	2	3
Moving/Speaking slowly enough for others to notice.	0	1	2	3
Feeling fidgety/restless (enough for others to notice)	0	1	2	3
Suicidal thoughts/thoughts of hurting yourself	0	1	2	3

INTERPRETATION OF TOTAL SCORE:

1-4	Minimal Depression	+	+	+	=
5-9	Mild Depression				
10-14	Moderate Depression				
15-19	Moderately Severe Depression				TOTAL
20-27	Severe Depression				SCORE