FAMILY CARE CENTERS
MEDICAL GROUP INC

Annual Wellness Visit Summary

Patient Name: _____

Date Of Birth: _____

Today's Date:_____

Patient Age: _____ Male / Female

☐ **Current Medications Including over the counter and Vitamins**

_____

_____

_____

_____

_____

_____

_____

☐ **Physical Health:** Any change from last year?
Yes / No

☐ **Pain Screening** (circle one)
(Low) 0 1 2 3 4 5 (High)

☐ **Urine Leakage** Yes / No

☐ **Balance/Falls:** Any trouble walking or standing? Yes / No

☐ **Social & Emotional support:** Do you have what you need? Yes/ No

☐ **Health habits:** Do you…

Smoke? Yes / No If yes, how many/day?____Years?____
Drink Alcohol? Yes/ No
If yes, # of drinks/_____wk? or day?

☐ **Nutrition:** Did you lose or gain more than 5 pounds in the last month? Yes / No

☐ **Sleep:** Do you have difficulty falling or staying asleep? Yes / No

☐ **Exercise:** Do you exercise?

If yes, how often? _____/ Week

Check each symptom with which you are having *increasing difficulty*, compared to your past ability:

☐ Forgetting important details of things I have done in the past few weeks.
☐ Forgetting to do things I said I would do.
☐ Retelling a story or joke to the same person because I forgot that I had already told them.
☐ Completing complex tasks at work or home (i.e. balancing checkbook, planning projects).
☐ None of the above.

Compared to 10 years ago, my memory **now** is: (circle one)

A lot worse A little better
A little worse A lot better
The same Not sure

☐ **Advance Directive:** Do you have one in place?
Yes / No

Physician Section

☐ **Eye Exams**
Referral given OR
Completed or not necessary

☐ **Colorectal Screening**
Referral given OR
Completed or not necessary

☐ **Mammogram**
Order given OR Completed
or not necessary

☐ **Bone Density Test**
Order given OR Completed
or not necessary

☐ **Cholesterol Test** (especially if you have diabetes or Heart disease)
Order given OR
Completed or not necessary

☐ **Vaccines:** ☐ pneumovax / ☐ flu / ☐ shingles / ☐ other?
(Circle all vaccines that apply)

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Annual Wellness Summary Continued

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Please provide a list of all other physicians you currently see or have seen this year:

Name	Specialty	Reason

Please provide a list of all vendors you obtain medical supplies from:

_____

_____

Hearing	**Circle Response**
Do you have trouble hearing the TV or telephone when others do not?	Yes No
Do you have to strain to hear/understand conversations?	Yes No

Home Safety

Does your home have "throw" rugs?	Yes No
Do you use a non-slip bath mat in the tub or shower?	Yes No
Do you have handrails on all steps and stairs?	Yes No
Does your home have working smoke detectors?	Yes No

Daily Routine

Do you live alone? Yes No

Do you need help with any of the following? (Please circle all that apply)

☐ Preparing meals ☐ Shopping ☐ Driving/transportation ☐ Bathing
☐ Walking distances ☐ Managing your finances

Vision Assessment - Have you seen an optometrist or ophthalmologist in the last year? Yes No

Do you wear glasses or contacts? Yes No

Office Staff ONLY	**Uncorrected**	**Corrected**
Right Eye (OD)	_____	_____
Left Eye (OS)	_____	_____
Both eyes (OU)	_____	_____

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Mental Health Screen

Patient Name: _____ Today's Date:_____

Date of Birth: _____

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	0 ○	1 ○	2 ○	3 ○
2. Feeling down, depressed, or hopeless	0 ○	1 ○	2 ○	3 ○
3. Trouble falling or staying asleep, or sleeping too much	0 ○	1 ○	2 ○	3 ○
4. Feeling tired or having little energy	0 ○	1 ○	2 ○	3 ○
5. Poor appetite or overeating	0 ○	1 ○	2 ○	3 ○
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0 ○	1 ○	2 ○	3 ○
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ○	1 ○	2 ○	3 ○
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	0 ○	1 ○	2 ○	3 ○
9. Thoughts that you would be better off dead, or of hurting yourself	0 ○	1 ○	2 ○	3 ○

Add columns _____ + _____ + _____

TOTAL: _____

10. If you checked off *any* problems, 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 ○

FAMILY CARE CENTERS
MEDICAL GROUP INC

COPD Population Screen

Patient Name: _____ Today's Date: _____

Date of Birth: _____

This survey asks questions about you, your breathing and what you are able to do. To complete this survey, mark an **X** in the box that best describes your answer for each question below.

1. During the past 4 weeks, how much of the time did you feel short of breath?

None of the time	A little of the time	Some of the time	Most of the time	All of the time
◯ 0	◯ 0	◯ 1	◯ 2	◯ 2

2. Do you ever cough up any "stuff", such as mucus or phlegm?

No, never	Only with occasional colds or chest	Yes, a few days a month	Yes, most days of the week	Yes, everyday
◯ 0	◯ 0	◯ 1	◯ 1	◯ 2

3. Please select the answer that best describes you in the <u>past 12 months.</u>
I do less than I used to because of my breathing problems.

Strongly disagree	Disagree	Unsure	Agree	Strongly Agree
◯ 0	◯ 0	◯ 0	◯ 1	◯ 2

4. Have you smoked at least 100 cigarettes in your ENTIRE LIFE?

No	Yes	Don't know
◯ 0	◯ 2	◯ 0

5. How old are you?

Age 35 – 49	Age 50 – 59	Age 60 – 69	Age 70+
◯ 0	◯ 0	◯ 2	◯ 2

How to score your survey: In the spaces below, write the number that is next to your answer for each of the questions. Add the nu7mbers to get the total score. The total score can range from 0 to 10.

_____+_____+_____+_____+_____ = _____

#1 **#2** **#3** **#4** **#5** **TOTAL SCORE**