PREMIERMED FAMILY AND SPORTS MEDICINE
Annual Wellness Visit Form 2022

Patient First/Last Name: ____ Date: ____/____/_______
Annual Wellness Visit (AWV) Scheduled for: Date: ____/____/_______

This visit is covered every 12 months to help you stay healthy

- This visit includes a review of medications/vitamins and supplements you are taking.
- This visit helps your doctor identify any health risks you may have
- It is a time where your doctor provides you with personalized health advice and puts together a plan to keep you healthy.

What to bring to the appointment?

▢ All of the medications/supplements/vitamins you are currently taking
▢ A list of your current physicians (Ex: ophthalmology, cardiology, podiatry, vascular surgeon, etc.)
▢ The names and locations of your pharmacies
▢ The names of any home health agencies that are providing you services
▢ The name of your medical equipment companies (Ex: oxygen supplier)
▢ A list of any recent immunizations you have received (Ex: tetanus, shingles, flu, pneumonia etc.)
▢ Your home safety checklist completed

Referral Recommendations:

HHC: __________________ PT Eval: _________________ Psych/Counseling: ___________________

Optometry: __________________ Dental: _____________________ Dietician: ___________________

Other: ____

Things my loved ones may need to know:

____

Vaccines Recommended:

▢Pneumococcal ▢Influenza ▢Hepatitis B ▢Shingles Other: ____________________________

Schedule for:

▢Mammogram ▢Pap Smear ▢Colonoscopy ▢Dexa Scan ▢Prostate Exam
Lab Work Due: ______________________ Follow Up Appointment Due: ________________________
Patient First/Last Name: ____________________________________ Date: ____/____/_______

FLOORS

When you walk through a room, do you have to walk around furniture?	YES	NO	Ask somebody to move the furniture so your path is clear
Are there objects on the floor (papers, shoes, etc.) in your way when you walk through?	YES	NO	Pick up things on the floor and always keep the pathway clear.
Do you have to walk over or around wires or cords?	YES	NO	Coil or tape cords to the wall. If needed, have an electrician put in a new outlet.
Do any of your carpets have bumps or curled ends and do not lie flat?	YES	NO	Remove them or use double-sided tape or a non-slip backing so they don't move.

STAIRS

Is there a single switch for the stairs placed at either the top or the bottom?	YES	NO	Have an electrician install a light switch at the other end.
Do you have trouble seeing the outline of the steps due to poor lighting?	YES	NO	Have someone install a stronger light bulb or another light fixture.
Are the handrails only on one side, or loose or broken?	YES	NO	Fix loose or broken handrails, and make sure they are placed on both sides, and run the full length of the stairs.
Are any stairs loose or uneven?	YES	NO	Fix loose or uneven stairs.
Is the carpet or covering on the stairs loose, worn or torn?	YES	NO	Make sure the carpet or other covering is secure.

BEDROOM

Do you have to walk through the room in the dark to reach a light switch?	YES	NO	Install a light switch near the entrance to the room to avoid walking in the dark.
Is the light near your bed hard to reach?	YES	NO	Place a lamp close to your bed where it is easy to reach.
Is the path from your bedroom to the bathroom dark?	YES	NO	Put in a nightlight so you can see where you're walking.

KITCHEN AND EATING AREAS

Are the things you use regularly stored too high or too low?	YES	NO	Move items you use frequently to areas in easy reach.
Is your step stool unsteady?	YES	NO	If you must use a step stool, make sure it is stable and has a bar to hold on to.

BATHROOM

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Is your tub or shower floor slippery?	YES	NO	Put a non-slip rubber mat or abrasive strips on the tub or shower floor.
Do you have difficulty getting into or out of the shower or tub?	YES	NO	Install sturdy grab bars in your tub or shower.
Do you have difficulty getting onto or off of the toilet?	YES	NO	Use a seat riser or install a grab bar next to your toilet.

OUTSIDE THE HOUSE

Is the entrance to your home poorly lit?	YES	NO	Install a front light or lighting along the path to your house.
Does the walkway to your house have cracks or holes?	YES	NO	Repair the walkway.

FALL RISK ASSESSMENT

Y (2) N	I have fallen in the past year.	People who have fallen once are likely to fall again.
Y (2) N	I use or have been advised to use a cane or walker.	People who have been advised to use a walker or can may already be likely to fall.
Y (1) N	Sometimes I feel unsteady when I walk.	Unsteadiness or needing support while walking are signs of poor balance.
Y (1) N	I steady myself by holding onto furniture when walking at home.	This is a sign of poor balance.
Y (1) N	I am worried about falling.	People who are worried about falling are more likely to fall.
Y (1) N	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Y (1) N	I have some trouble stepping onto a curb.	This is a sign of weak leg muscles..
Y (1) N	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Y (1) N	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Y (1) N	I take medicine that sometimes makes me feel lightheaded.	Side effects from medicines can sometimes increase your chance of falling.
Y (1) N	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Y (1) N	I often feel sad or depressed.	Symptoms of depression such as not feeling well or slowed down have been linked to falls.

Add up the number of points. If you scored more than 4 points, you may be at risk of falling.
T: ______

ALCOHOL DEPENDENCE ASSESSMENT

How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times a week
How many drinks containing alcohol do you have in a typical day?	1 or 2	3 or 4	5 or 6	7 or 9	10 or more
How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	weekly	Daily or almost daily
How often in the past year have you found you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	weekly	Daily or almost daily
How often in the past year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	weekly	Daily or almost daily
How often in the past year have you needed a drink in the morning after a heavy drinking session?	Never	Less than monthly	Monthly	weekly	Daily or almost daily
How often in the past year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	weekly	Daily or almost daily
How often in the past year have you been unable to remember the night before because of drinking?	Never	Less than monthly	Monthly	weekly	Daily or almost daily
Have you or someone else been injured because of your drinking?	No		Yes, but not in a year		Yes, during the past year
Has a friend, relative, doctor, or coworker been concerned about your drinking?	No		Yes, but not in a year		Yes, during the past year

Question 2 or 3 $\geq$ 1 indicates hazardous drinking
Question 4-6 >0 implies the presence or incipience of alcohol dependence
Questions 7-10 >0 Indicates harmful drinking
Questions 9-10 also review to determine evidence of a past problem

In the US a single drink serving contains about 14g ethanol or pure alcohol. Although the following drinks are different sizes, each one contains the same amount of pure alcohol in a single drink: 12oz of beer, 8-9oz malt liquor, 5oz wine, 1.5oz of hard liquor.

Patient First/Last Name: ______________________________________ Date: ____/____/_______

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DEPRESSION SCREENING

Are you usually satisfied with your life?	Yes	No
Have you dropped many of your past activities and interests?	Yes	No
Do you feel that your life is empty?	Yes	No
Do you often get bored?	Yes	No
Are you in a good spirit most of the time?	Yes	No
Are you afraid that something bad is going to happen to you?	Yes	No
Do you feel happy most of the time?	Yes	No
Do you often feel helpless?	Yes	No
Do you prefer to stay at home rather than going out and doing things?	Yes	No
Do you feel that you have more problems with memory than most?	Yes	No
Do you think it is wonderful to be alive now?	Yes	No
Do you feel worthless the way you are now?	Yes	No
Do you feel full of energy?	Yes	No
Do you feel that your situation is hopeless?	Yes	No
Do you think that most people are better off than you?	Yes	No

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RAPID COGNITIVE SCREEN:

Is the patient alert? __________ **Level of Education:** ____________

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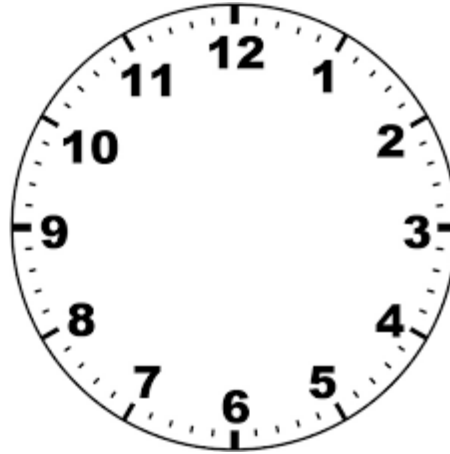
1. Please remember these 5 objects, I will ask you what they are later:

   Apple Pen Tie House Car

2. This is a clock face. Please draw the hour and minute markers to read ten minutes to eleven o'clock.



   __/2-hour markers okay __/2 time correct

3. What were the 5 objects I asked you to remember?

   __/1 Apple __/1 Pen __/1 Tie __/1 House __/1 Car

4. I'm going to tell you a story. Please listen carefully, afterwards I am going to ask you about it.
   Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had 3 children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

   What state did she live in?
   ___/1 Illinois

   _____Total score
   8-10 normal 6-7 Mild Cognitive Impairment 0-5 Dementia

Patient First/Last Name: ____________________________________ Date: ____/____/_______

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TUG TEST (TIMED UP AND GO):

Purpose: To assess mobility

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Directions: Patients wear their regular footwear and can use a walking aid if needed. Begin by having the patient sit back in a standard armchair and identify a like 3 meters or 10 feet away on the floor.

Instructions to the patient

When I say "GO", I want you to:

- Stand up from the chair
- Walk to the line on the floor at your normal pace
- Turn
- Walk back to the chair at your normal pace.
- Sit down again

On the word "GO", begin timing.

Stop timing after the patient has sat back down and record the time.

Time: ________ Seconds

An older adult who takes ≥ 12 seconds to complete the TUG is at high risk for falling

Observe the patient's postural stability, gait, stride length and sway.

Circle all that apply:

- Slow tentative Pace
- Loss of balance
- Short Strides
- Little or no arm swing
- Steadying self on walls
- Shuffling
- No trouble turning
- Not using assistive device properly

Notes: ____
____
____
____

Patient First/Last Name: ________________________________ Date: ____/____/_______

PREMIERMED FAMILY AND SPORTS MEDICINE

Annual Wellness Visit Form 2022

(Please do not leave any field blank; if something does not apply, write "N/A". If unknown, write "unknown")

Patient First/Last Name: ____
Date of Birth: ____/____/_______ Social Security #: _________ - ________ - _________
Mailing Address: ____
City: _______________________ State: ________________ Zip Code: ______________

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Phone: ________________________ Secondary Phone: ________________________
Email Address: ____

Marital Status: ▢Single ▢Married ▢Divorced ▢Widowed ▢Separated

Sex: ▢Male ▢Female Gender: ___________ Pronouns: ___________

Race: ▢White ▢Black or African American ▢American Indian or Alaska Native ▢Asian ▢Native Hawaiian or Pacific Islander ▢Decline

Ethnicity: ▢Hispanic/Latino ▢Not Hispanic/Latino ▢Decline

EMERGENCY CONTACT & CONSENT FOR DISCLOSURE

I agree that PremierMED Family & Sport Medicine may disclose my medical information to me and the following individual(s) in the event I am not physically present, including disclosures by telephone, voice mail, facsimile, e-mail, or regular mail. I agree to let certain individual(s) participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for PremierMED Family & Sport Medicine and/or staff to disclose my personal medical information to the following individuals.

Contact First/Last Name: ____
Relation: ________________________ Contact Number: __________________________
Mailing Address: ____
City: _______________________ State: ________________ Zip Code: _____________

INSURANCE

Insurance: ____
Policy Number: ___________________________ Group Number: __________________
Policy Holder: _____________________________ Relation to Patient: _____________
Date of Birth: ____/____/_______ Policy Holder SSN: ________ - _______ - ________

Secondary Insurance: ____
Policy Number: ___________________________ Group Number: __________________
Policy Holder: _____________________________ Relation to Patient: _____________
Date of Birth: ____/____/_______ Policy Holder SSN: ________ - _______ - ________

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SCANNED PICTURE ID: _________ SCANNED INSURANCE CARD: ________

ALL FORMS REVIEWED BY: ____________

MEDICAL HISTORY (Leave blank if no past/current medical history)

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1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______

SURGICAL HISTORY (Leave blank if no surgical history)

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______

Do you currently see any specialists? (Please list the name, specialty, and location.)

______
______
______
______

Do you need any referrals today? If so, please state the type of specialist and the reasoning for the referral. If you have the provider picked out please list that as well.

______

CURRENT MEDICATIONS (Leave blank if not currently taking medications)

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
10. ______

ALLERGIES/MEDICATION SIDE EFFECTS (Please list the agent/medication and reaction)

______
______
______

SOCIAL HISTORY

Occupation: ______ Employer: ______

▢Retired ▢Homemaker ▢Student ▢Unemployed

Who lives with you?

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▢Spouse/Partner ▢Children ▢Roommates ▢Parents ▢Other

Tobacco use (including cigars/vape/smokeless):
▢Current everyday ▢Current someday ▢Former smoker ▢Never used

Alcohol use (beer/wine/liquor):
▢1-3 ▢4-6 ▢7+ per ▢Day ▢Week ▢Month ▢Year ▢No alcohol use

FEMALES

Currently menstruating: Date of last menstruation: ____/____/_______
▢Normal cycles ▢Abnormal cycles, please explain: _______________________________

No longer menstruating:
▢Natural menopause ▢Hysterectomy Date ____/____/_______ ▢Other ______________
Are you breastfeeding or pregnant? ▢Yes ▢No

Are you using any type of birth control?
If yes, what kind and when did you start using it?____________________________________
If not, are you interested in discussing birth control options during your visit? ▢Yes ▢No
Date of last PAP smear: ____/____/_______ Date of last mammogram: ____/____/_______

MALES

Date of last prostate exam: ______________
Have you noticed any testicular pain or lumps/bumps? ▢Yes ▢No
If so, location ____________________ how long as this been present?____________

ALL

Date of last ▢Colonoscopy ▢Cologuard ▢FOBT: ____/____/_______
Last DEXA scan: ____/____/_______
Last eye exam: ____/____/_______ Performing provider: __________________
Last annual wellness exam: ____/____/_______ Performing provider: _________________
How often do you exercise? ____________________________________
Do you eat a well-balanced diet? ▢ Yes ▢ No
Are you on any special diet or dietary restrictions? _________________________________

VACCINATIONS

Shingles ▢Yes ▢No
Influenza ▢Yes ▢No
Pneumonia ▢Yes ▢No
Tetanus, Diphtheria, Pertussis (Tdap) ▢Yes ▢No
Hepatitis A ▢Yes ▢No
Hepatitis B ▢Yes ▢No
COVID19 ▢Yes ▢No

Are you interested in receiving any vaccines during today's visit? ▢Yes ▢No

FAMILY HISTORY

Father: ▢Living ▢Deceased
History of: ▢High blood pressure ▢Diabetes ▢ Cancer, type: _________ ▢Stroke
Other ____

Mother: ▢Living ▢Deceased
History of: ▢High blood pressure ▢Diabetes ▢ Cancer, type: _________ ▢Stroke
Other ____

Other significant family history: ____

PREFERRED PHARMACY

Name: ________________________________ Phone: __________________________
Address: ____
City: ________________________ State: ________________ Zip Code: ____________