WESTERN WAKE WELLNESS

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WESTERN WAKE WELLNESS, PLLC
ANNUAL WELLNESS VISIT

Patient Name: _____ **Birth Date**: _____ **Age**: _____ **Today's Date:** _____
Name I would like to be called: _____ **Pharmacy Name & Location:** _____

ALLERGIES TO MEDICATION OR FOODS	Reaction:

CURRENT MEDICATIONS
Please list all prescription medications, over the counter, herbal or natural supplements, inhalers, nasal sprays or creams.

Name	Dose	Frequency	Name	Dose	Frequency

SURGERIES

Date	Which hospital	Type of Surgery

HOSPITAL ADMISSIONS

Date	Which hospital	Reason for Admission

SPECIALTY PROVIDERS To help us coordinate your care, please list any medical providers you see outside of this practice:

□ Cardiology	□ Dermatology	□ ENT/Otolaryngology	□ Infectious Disease
□ Pulmonology	□ Nephrology	□ Allergy/Immunology	□ Podiatrist
□ OB/Gynecology	□ Gastroenterology	□ Orthopedics	□ Ophthalmology/Optometry
□ Urology	□ Neurology	□ Rheumatology	□ Psychiatrist/Psychologist
□ Endocrinology	□ Pain Specialist	□ Hematology/Oncology	□ Surgeon

PROVIDER INFORMATION

NAME	REASON	LAST VISIT	NEXT VISIT

SOCIAL HISTORY

How often do you exercise? □ None □ 1-2x weekly □ 3-5x weekly □ Every day Doing what:

Tobacco Use: □ Never □ Former Smoker: When did you quit?

Alcohol Use: □ No □ Yes In the last 7 days, how many days did you drink alcohol?

Recreational Drug Use: □ No □ Past □ Current

Caffeine Use: □ No □ Yes □ Coffee □ Soda □ Tea □ Diet pills or supplements How many per day?

How many people live in your household? **Who lives with you?** □ Spouse □ Children □ Other:

Are there any changes in your living situation? □ No □ Yes If so, please detail here:

FUNCTIONAL STATUS

In general, would you say your health is: □ Excellent □ Very Good □ Good □ Fair □ Poor

How have things been going for you during the past 4 weeks?

□ Very well; could hardly be better □ Pretty well □ Good and bad parts about equal □ Pretty bad □ Very bad; could hardly be worse

During the past 4 weeks, how much bodily pains have you generally had?

□ No pain □ Very mild pain □ Mild Pain □ Moderate Pain □ Severe Pain

During the past 4 weeks, how much have you been bothered by feelings of anxiety, depression, irritability, or sadness?

□ Not at all □ Quite a bit □ Slightly □ Moderately □ Extremely

During the past 4 weeks, has your physical or emotional health limited your social activities with family and friends?

□ Not at all □ Quite a bit □ Slightly □ Moderately □ Extremely

How often in the last 4 weeks have you been bothered by any of the following problems:

Falling or dizzy when standing up	□ Never	□ Seldom	□ Sometimes	□ Often	□ Always
Sexual problems or concerns	□ Never	□ Seldom	□ Sometimes	□ Often	□ Always
Trouble eating well	□ Never	□ Seldom	□ Sometimes	□ Often	□ Always
Teeth or denture problems	□ Never	□ Seldom	□ Sometimes	□ Often	□ Always
Problems using the phone	□ Never	□ Seldom	□ Sometimes	□ Often	□ Always
Tiredness or fatigue	□ Never	□ Seldom	□ Sometimes	□ Often	□ Always
Problems sleeping	□ Never	□ Seldom	□ Sometimes	□ Often	□ Always

Do you have difficulty getting out of a chair or car without assistance? □ No □ Yes

Have you fallen <u>two or more times</u> in the past year? □ No □ Yes

Are you afraid of falling? Do you feel unsteady? □ No □ Yes

Do you use a cane or walker? □ No □ Yes

HEARING LOSS SCREENING

How often in the <u>last 4 weeks</u> have you experienced the following?

Straining to understand conversation: □ Never □ Seldom □ Sometimes □ Often □ Always

Trouble hearing in a noisy background: □ Never □ Seldom □ Sometimes □ Often □ Always

Misunderstanding what others are saying: □ Never □ Seldom □ Sometimes □ Often □ Always

Do you notice any new or worsening problems with your vision? □ No □ Yes

How confident are you that you can control and manage most of your health problems/issues?

□ Very Confident □ Somewhat confident □ Not very confident □ I do not have any health problems

How often do you have trouble taking medications the way you have been told to take them?

□ I do not have to take medicine □ I always take them as directed

□ Sometimes I have trouble taking them as directed □ I seldom take them as directed or often have trouble taking them as directed

Do you have someone who is available to help you if you needed or wanted help?

□ No □ Yes, as much as I want/need □ Yes, some

Do you need help with shopping, transportation, preparing meals, or taking your medications correctly? □ No □ Yes

If so, please describe:

Because of any health problems, do you need the help of another person with your personal care needs, such as eating, bathing, dressing, or getting around the house? □ No □ Yes

If so, please describe:

Can you handle your own money without help? □ No □ Yes

Are you have difficulties driving your car? □ No □ Yes, often □ Sometimes □ N/A, I do not use a car

Do you always fasten your seat belt when you are in a car? □ Yes, always/usually □ Yes, sometimes □ No

HOME SAFETY

Does your home have smoke or carbon monoxide alarms? □ No □ Yes

Is your home well lit, especially when you get up at night? □ No □ Yes

Are your sidewalks/entryways well maintained? □ No □ Yes

Do you have rails on stairs? □ No □ Yes

Do you have grab bars in the bathroom? □ No □ Yes

Do you have throw rugs, electrical cords, or other obstacles in your walking space? □ No □ Yes

Are all medicines kept in original containers with original labels intact? □ No □ Yes

Do you throw out all unidentified or out-of-date medications? □ No □ Yes

ADVANCED DIRECTIVES

Do you have a Healthcare POA or Living Will? □ No □ Yes **Would you like to discuss Advance Directives?** □ No □ Yes

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

□ No □ Yes Please describe: