Saint Mary's Medical Group

Affix Patient Label or

Patient Name_____

DOB _____

Wellness Visit Assessment

Today's Date: _____

DOB: _____ **Gender:** ☐ **Male** ☐ **Female**

Patient Name: _____

Welcome to your annual wellness visit! Thank you for choosing Saint Mary's Medical Group. We look forward to providing the best quality care to all of our patients. The exam performed at our Wellness Clinic includes the following:

- A review of a patient's medical and social history
- A review of potential risk factors for depression and other mood disorders
- A safety and functional ability review
- A discussion of end-of-life planning **(if you currently have an Advanced Directive please bring a copy to your visit)**
- Vaccinations
- Referrals for preventative services such as: Mammogram, Bone Density, Colonoscopy, Lab work, Cardiovascular testing, Glaucoma testing, and Medical Nutrition Therapy

This risk assessment is designed to help us provide you with better healthcare. If there are any questions which you are uncomfortable answering, please leave them blank.

What is your current marital status?

□ Married □ Divorced □ Separated □Widowed
□ Domestic Partnership □ Never Married

Do you live alone? □ Yes □ No

Please rate your current pain level on a scale from 0 – 10
(0 being no pain at all and 10 being worst pain possible) Pain level _____

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Functional Ability / Safety / Home Environment

Because of a health or physical problem, do you have any difficulty doing the following activities **without special equipment or help from another person**? (Please place an X in the appropriate box)

Activity	**Able To:**	**Not Able to:**	**Find it Difficult to:**
Climb Stairs			
Exercise			
Getting in or out of chairs/cars			
Go down stairs			
Go up stairs			
Kneel			
Eat			
Bathe			
Dress			
Put on socks and shoes			
Walk			
Walk 10 blocks			
Walk an unlimited distance			
Walk 5 to 10 blocks			

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Do you have: Smoke detectors in your home? …… □ Yes □ No
Firearms in your home? …… □ Yes □ No
Do you use a seatbelt in your vehicle? …… □ Yes □ No
Do you have Carbon Monoxide detectors in home? …… □ Yes □ No
Do you have Radon in home? □ Yes □ No □ Treated □ Untested

Type of home heating: _____
(Ex: coal, electric, gas, oil, solar, wood)

Have you fallen in the past year? …… □ Yes □ No
(A fall is when your body goes to the ground without being pushed)

How many times? _____

Were you using an assistive device? (Ex: Cane, Walker, Wheelchair) …… □ Yes □ No

Date the last fall occurred? _____

Did the fall result in injury? …… □ Yes □ No

Circumstances of the fall

a. Tripped / Stumbled over something …… □ Yes □ No
b. Lightheadedness / Pounding Heart Rate …… □ Yes □ No
c. Unable to get up within 5 minutes …… □ Yes □ No
d. Needed assistance to get up …… □ Yes □ No
e. Loss of Consciousness …… □ Yes □ No
f. Were you seen in the Emergency Department? …… □ Yes □ No

Do you have a device for mobility? …… □ Yes □ No

Please Circle: Cane Walker Wheelchair Other: _____

Are you physically active? (Ex: Walking, Group Classes, Stationary Bike, etc.) …… □ Yes □ No

How many times per week do you exercise? _____

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Nutrition

Do you follow a medically prescribed diet? □ Yes □ No What type? _____

Have you been eating more/less than usual in the past three months? …….. □ Yes □ No

Have you gained/lost any weight unintentionally in the past three months? …….. □ Yes □ No

Cognitive Health

Have you had any problems with your short-term memory? …… □ Yes □ No
(Ex: What did you have for dinner last night?)
Have you had any problems with your long-term memory? …… □ Yes □ No
(Ex: Where were you born?)

Health

Do you have a history of asthma or COPD? …….. □ Yes □ No

How would you rate your overall health?
(Please Circle One) Fair Poor Good Excellent

Compared to one year ago, how would you rate your physical health?
(Please Circle One) Fair Poor Good Excellent

Compared to other people your age, would you say your overall oral and dental health is?
(Please Circle One) Fair Poor Good Excellent

Do you have vision problems? …….. □ Yes □ No
Any recent vision changes? …… □ Yes □ No
Have you had an eye exam in the last 12 months? □ Yes □ No

If yes, where was this exam performed? _____

Do you have hearing problems? …… □ Yes □ No
Any recent hearing changes? …… □ Yes □ No

Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine? □ Yes □ No

Are you currently sexually active? ..... □ Yes □ No

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Tobacco / Alcohol/ Medications

Do you use tobacco? □ No □ Yes □ Former Age Started: _____ Age Stopped: _____

Passive smoke exposure? □ Yes □ No □ Former

Do you drink alcohol? □ Yes □ No □ Former
(If yes please answer the following):

- Have you ever felt you should cut down on your drinking? ____Yes ____No
- Have people annoyed you by criticizing your drinking? ____Yes ____No
- Have you ever felt bad or guilty about your drinking? ____Yes ____No
- Have you ever had a drink first thing in the morning to ____Yes ____N0
  To steady your nerves or to get rid of a hangover (Eye Opener)

Have you used drugs other than those required for medical reasons? ____Yes ____No

Have you abused prescription drugs? ____Yes ____No

Do you abuse more than one drug at a time? ____Yes ____No

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Emotional Health

Over the last *2weeks,* 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**

10. If you checked *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 _____

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Provider List

(PLEASE ALSO INCLUDE ALL MEDICAL EQUIPMENT AND SUPPLIERS)

PROVIDER NAME	SPECIALTY

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Medication List

(PLEASE ALSO INCLUDE ALL OVER THE COUNTER MEDICATIONS)

MEDICATION NAME	DOSAGE	INSTRUCTIONS

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Sleep Apnea Screening

Last Name: _____ First Name: _____ Birth Date: _____ Sex: M / F

Height: _____ Weight _____ BMI _____ Neck Circumference _____

Sleep Apnea Questionnaire

STOP	YES	NO
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors?		
Do you often feel **T**IRED, fatigued, or sleepy during the daytime?		
Has anyone **O**BSERVED you stop breathing (choking, gasping) during your sleep		
Do you have or are you being treated for High Blood **P**ressure?		

BANG	YES	NO
BMI more than 35kg/m2?		
AGE over 50 years old?		
NECK circumference >16 inches (40cm)?		
Gender: Male?		

TOTAL SCORE		

High Risk of OSA: Yes 5-8 **Moderate risk of OSA: Yes 3-4** **Low risk of OSA: Yes 0-2**

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Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to think about how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = *Never* doze 1 = *Slight* chance of dozing 2 = *Moderate* chance of dozing 3 = *High* chance of dozing

Chance of Dozing Score 0-3:	Situation:
_____	Sitting and reading
_____	Watching TV
_____	Sitting, inactive in a public place (i.e. theater or in a meeting)
_____	As a passenger in a car for an hour without a break
_____	Laying down to rest in the afternoon when circumstances permit
_____	Sitting and talking to someone
_____	Sitting quietly after lunch without alcohol
_____	In a car while stopped for a few minutes in traffic
_____	**Total (This is your Epworth Sleepiness Score)**

Score: Add up your score for each scenario. 0-10 Normal range 10-12 Borderline 12-24 Sleepy

Other Risk Indicators for OSA

- ☐ Coronary artery disease or heart attack
- ☐ Atrial fibrillation or other heart rhythm problems
- ☐ Congestive heart failure
- ☐ Type 2 Diabetes
- ☐ Stroke
- ☐ Auto Accident or near accident due to sleepiness

Sleep Consult/Study should be ordered if:

High in either test

Moderate in both tests

Moderate in either test with one or more other indicator

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Review of Systems – Please check all symptoms you are CURRENTLY experiencing

YES	GENERAL	YES	GENITOURINARY	YES	SKIN
	Chills		Painful urination		Breast discharge
	Fatigue		Blood in urine		Breast lump
	Fever		Increased urine		Brittle hair
	Malaise		Urinary frequency		Brittle nails
	Night Sweats		Urinary incontinence		Hair loss
	Weight gain		Urinary retention		Abnormal hair growth
	HEENT		**REPRODUCTIVE (FEMALE)**		Hives
	Ear drainage		Abnormal pap smear		Itching
	Ear pain		Painful or irregular periods		Rash
	Eye discharge		Painful intercourse		Skin lesion
	Eye pain		Hot flashes		**PSYCHIATRIC**
	Hearing loss		Vaginal discharge		Anxiety
	Nasal drainage		**REPRODUCTIVE (MALE)**		Depression
	Sinus pressure		Erectile dysfunction		Insomnia
	Sore throat		Penile discharge		**HEMATOLOGIC/LYMPHATIC**
	Visual changes		**METABOLIC/ENDOCRINE**		Easy bleeding
	RESPIRATORY		Cold intolerance		Easy bruising
	Chronic cough		Heat intolerance		Enlarged lymph nodes
	Cough		Increased thirst		**IMMUNOLOGIC**
	Known TB exposure		Increased Hunger		Contact allergies
	Shortness of breath		**NEUROLOGIC**		Environmental allergies
	Wheezing		Dizziness		Food allergies
	CARDIOVASCULAR		Extremity numbness		Seasonal allergies
	Chest pain		Extremity weakness		**OTHER (please list)**
	Leg pain with activity		Gait disturbance		
	Swelling		Headache		
	Palpitations		Memory loss		
	GASTROINTESTINAL		Seizures		
	Abdominal pain		Tremors		
	Blood in stools		**MUSCULOSKELETAL**		
	Change in stools		Back pain		
	Constipation		Joint pain		
	Diarrhea		Joint swelling		
	Heartburn		Muscle weakness		
	Loss of appetite		Neck pain		
	Nausea				
	Vomiting				

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