A WORD TO OUR PATIENTS ABOUT YOUR ANNUAL WELLNESS VISIT

Dear Patient,

Your appointment for your Annual Wellness Visit is scheduled for _____. We want you to receive wellness care – health care that may lower your risk of illness or injury. The term "physical" is often used to describe wellness care. Commercial health insurance generally covers a wellness visit once a year to identify health risks and develop a plan to keep you healthy. At your wellness visit, our health care team will:

- Collect vital signs (vision, height/weight, blood pressure)
- Perform a physical examination evaluating the following
  - General appearance
  - Head/Neck
  - Heart
  - Lungs
  - Abdomen
  - Neurologic
  - Skin
  - Extremities
  - Breast
  - Genital exam
  - Rectal exam
  - Pelvic exam
  - Pap smear
- Review and update medical history, surgical history, family history, social history
- Screen for alcohol/tobacco/drug use
- Screen for disease
- Order preventive wellness labs to include complete blood count (CBC); comprehensive metabolic panel (CMP); Lipid Panel; thyroid stimulating hormone (TSH); and urinalysis (UA). For females, a follicle stimulating hormone (FSH) test may be ordered and for males a prostate specific antigen (PSA) test and total testosterone test may be ordered. Any additional medically necessary labs may be ordered under a medical diagnosis code rather than a preventive wellness diagnosis code and may result in additional patient financial responsibility to the laboratory that processes the lab specimens.
- Review immunizations and administer necessary immunizations
- Identify additional medical providers on healthcare team and obtain reports if necessary
- Identify and order preventive health testing ie. colonoscopy, mammogram, dexa scan, eye exam, dental exam, specialist referral
- Review advanced directives and living will
- Promote healthy lifestyle
- Assess potential risk factors for future medical problems
- Provide risk factor reduction intervention

In order to prepare for your upcoming annual wellness visit, **please complete the information included in this packet and bring it with you to your visit**. Also, **review the attached immunization list**. If you have received any immunizations that are not listed, **please list them**. ***Please return these forms to our receptionist at check in on the day of your Annual Wellness Visit.***

Your commercial health insurance is very specific about what services must be provided and documented during your wellness visit. A wellness visit does not address new or existing health problems. That would be a separate service and requires a longer appointment. Please let our scheduling staff know if you need the medical provider's help with a health problem, a medication refill or something else. We will need to schedule a separate appointment for these services. *A separate charge applies to these services.*

We hope to help you get the most from your annual wellness benefits. Please contact our office with any questions.

Warmest regards,

Adam A. Brunson, MD

Name: _____ Date: _____ Date of Birth: _____

Annual Wellness Visit Health Risk Assessment

Please complete this checklist prior to seeing your medical provider. Your answers will help you receive the best health care possible.

General Health

1. In general, how would you rate your overall health?
   - ❑ Excellent
   - ❑ Very good
   - ❑ Good
   - ❑ Fair
   - ❑ Poor

2. Compared to one year ago, how would you rate your current overall health?
   - ❑ Much better
   - ❑ Somewhat better
   - ❑ About the same
   - ❑ Somewhat worse
   - ❑ Much worse

3. How many hours of sleep do you usually get each night?
   - ❑ More than 8 hours
   - ❑ 6-8 hours
   - ❑ 4-5 hours
   - ❑ Less than 4 hours

4. During the **past year**, how much bodily pain have you generally had?
   - ❑ No pain
   - ❑ Very mild pain
   - ❑ Mild pain
   - ❑ Moderate pain
   - ❑ Severe pain

5. During the **past year**, have you been to the emergency room?
   - ❑ yes ❑ no

6. During the **past year**, have you had a hospital stay?
   - ❑ yes ❑ no

7. During the **past year**, have you been treated by another doctor or health care professional?
   - ❑ yes ❑ no

8. During the **past year**, have you received any vaccines or immunizations?
   - ❑ yes ❑ no

Physical Activity

9. How many days a week do you usually exercise?
   _____ days per week

10. On days when you exercise, for how long do you usually exercise?
    _____ minutes per day

11. How intense is your typical exercise?
    - ❑ Light (like slow walking)
    - ❑ Moderate (like brisk walking)
    - ❑ Heavy (like jogging)
    - ❑ Very heavy (like sprinting)
    - ❑ I do not exercise

Nutrition

12. On a typical day, how many servings of fruits and/or vegetables do you eat? (1 serving = 1 cup fresh vegetables, ½ cup cooked vegetables or 1 medium piece of fruit)
    _____ servings per day

13. On a typical day, how many servings of high fiber or whole grain foods do you eat? (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high fiber ready to eat cereal or ½ cup cooked cereal, brown rice or whole wheat pasta)
    _____ servings per day

14. On a typical day, how many servings of fried or high-fat foods do you eat? (examples include fried chicken, fried fish, bacon, French fries, potato chips, creamy salad dressings or mayonnaise)
    _____ servings per day

15. On a typical day, how many caffeinated drinks (coffee, tea, soda) do you drink?
    _____ drinks per day

16. On a typical day, how many 8 oz. glasses of water do you drink?
    _____ glasses per day

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Oral Health

17. How would you describe the condition of your mouth and teeth (including false teeth or dentures)?
    - ❑ Excellent
    - ❑ Very good
    - ❑ Good
    - ❑ Fair
    - ❑ Poor

18. How often do brush your teeth?
    - ❑ At least once daily
    - ❑ Most days of the week
    - ❑ Seldom
    - ❑ Never

19. Do you visit the dentist regularly?
    - ❑ yes ❑ no

Social History

20. Please describe your home environment.
    - ❑ House
    - ❑ Apartment
    - ❑ Condo
    - ❑ Mobile home
    - ❑ Assisted living
    - ❑ Other: _____

21. How many people live in your home?
    _____ persons

22. What is your marital status?
    - ❑ Married
    - ❑ Single
    - ❑ Divorced
    - ❑ Separated
    - ❑ Widowed

23. Are you sexually active?
    - ❑ Yes, with a monogamous partner
    - ❑ Yes, with multiple partners
    - ❑ No, not currently sexually active

24. My sexual partners are?
    - ❑ Male
    - ❑ Female
    - ❑ Male and female

25. Do you have any concerns about your sexual functioning?
    - ❑ yes ❑ no

26. Are you a smoker?
    - ❑ Never smoked
    - ❑ Former smoker
      Quit date: _____
    - ❑ Yes, and I might quit
    - ❑ Yes, but I am not ready to quit

27. Do you use a smokeless tobacco product?
    - ❑ yes ❑ no

28. During an average week, how many drinks of wine, beer, or other alcoholic beverages do you usually have?
    - ❑ 10 or more drinks per week
    - ❑ 6-9 drinks per week
    - ❑ 2-5 drinks per week
    - ❑ One drink or less per week
    - ❑ No alcohol at all

29. Do you use street drugs?
    - ❑ Prior use
    - ❑ Daily
    - ❑ Occasionally
    - ❑ Never

30. Do you have a history of drug or alcohol addiction?
    - ❑ yes ❑ no

Mental Health

31. Over the **past two weeks**, how often have you had little interest or pleasure in doing things?
    - ❑ Not at all
    - ❑ Several days
    - ❑ More than half the days
    - ❑ Nearly every day

32. Over the **past two weeks**, how often have you felt down, depressed or hopeless?
    - ❑ Not at all
    - ❑ Several days
    - ❑ More than half the days
    - ❑ Nearly every day

33. Over the **past two weeks,** how often have you felt nervous, anxious or on edge?
    - ❑ Not at all
    - ❑ Several days
    - ❑ More than half the days
    - ❑ Nearly every day

Name: _____ Date: _____ Date of Birth: _____

34. How often is stress/anger a problem for you?
    - ❑ Never or rarely
    - ❑ Sometimes
    - ❑ Often
    - ❑ Always

35. How well do you handle the stress/anger in your life?
    - ❑ I'm usually able to cope effectively
    - ❑ At times I have problems coping
    - ❑ I often have problems coping

36. Over the **past two weeks**, has your emotional health limited your social activities with family, friends, neighbors, or groups?
    - ❑ Not at all
    - ❑ Slightly
    - ❑ Moderately
    - ❑ Quite a bit
    - ❑ Extremely

37. How often do you get the social and emotional support you need?
    - ❑ Always
    - ❑ Usually
    - ❑ Sometimes
    - ❑ Rarely
    - ❑ Never

Functional Status

38. Do you have any hearing problems?
    ❑ yes ❑ no

39. Do others complain about your hearing?
    ❑ yes ❑ no

40. Do you have any disability or physical/mental impairment?
    ❑ yes ❑ no

Safety Screening

41. Do you always wear your seatbelt when you are in the car?
    ❑ yes ❑ no

42. Do you ever drive after drinking alcohol, or ride with a driver who has been drinking?
    ❑ yes ❑ no

43. Is the hot water temperature set below 120 degrees?
    ❑ yes ❑ no

44. Do you have smoke detectors in your home?
    ❑ yes ❑ no

45. Do you protect yourself from the sun when you are outdoors?
    ❑ yes ❑ no

46. When bicycling or skating, do you always wear a helmet?
    ❑ yes ❑ no

47. Are you exposed to any potentially harmful substances or conditions at your work place?
    ❑ yes ❑ no

48. Do you have any loaded firearms in your home?
    ❑ yes ❑ no

49. Are you ever physically injured, threatened, mentally abused or sexually abused at home?
    ❑ yes ❑ no

50. Do you feel safe in your home?
    ❑ yes ❑ no

51. Have you potentially been exposed to HIV or sexually transmitted disease?
    ❑ yes ❑ no

52. Do you ever engage in high risk sexual behavior, such as sex with multiple partners, unprotected sex (unless in monogamous relationship), or sex with a person who has multiple sexual partners or injects IV drugs?
    ❑ yes ❑ no

End of life planning

53. Do you have a living will or advance directive?
    ❑ yes ❑ no

Name: _____ Date: _____ Date of Birth: _____

Constitutional
- ☐ Chills
- ☐ Excessive fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weight gain (unintentional)
- ☐ Weight gain (intentional)

Eyes
- ☐ Loss of vision
- ☐ Blurry vision
- ☐ Eye drainage
- ☐ Eye pain
- ☐ Red eye
- ☐ Itchy eyes
- ☐ Spots before your eyes
- ☐ Glasses/contact lenses

Ears, Nose & Throat
- ☐ Loss of hearing
- ☐ Ringing in the ears
- ☐ Ear pain
- ☐ Frequent runny nose
- ☐ Frequent nose bleeds
- ☐ Nasal congestion
- ☐ Bleeding gums
- ☐ Loss of smell
- ☐ Loss of voice
- ☐ Sore throat
- ☐ Sore tongue
- ☐ Tooth pain
- ☐ Dentures
- ☐ Hearing aids

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Swollen ankles/feet
- ☐ Fainting spells
- ☐ Irregular heart beat
- ☐ Fast heart beat
- ☐ Leg/calf pain with walking
- ☐ Dizziness
- ☐ Shortness of breath when lying flat
- ☐ Varicose veins

Respiratory
- ☐ Recent cough
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Exposure to TB

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Stomach/abdomen pain
- ☐ Loss of appetite
- ☐ Bloating
- ☐ Constipation

Gastrointestinal (continued)
- ☐ Diarrhea
- ☐ Frequent heartburn/acid reflux
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Bloody stools
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Change in appearance of stool

Genitourinary
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Leakage of urine
- ☐ Waking up to urinate at night
- ☐ Frequent need to urinate
- ☐ Change in urine stream
- ☐ Genital sores/rashes
- ☐ Pelvic pain
- ☐ Frequent urinary infections

Male Only
- ☐ Difficulty with erections
- ☐ Lump on testicle
- ☐ Painful erections
- ☐ Penile discharge

Female Only
- ☐ Painful intercourse
- ☐ Bleeding after intercourse
- ☐ PMS (premenstrual tension)
- ☐ Heavy periods
- ☐ Frequent periods
- ☐ Infrequent periods
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Menopausal
- ☐ Currently using birth control
- ☐ Currently/possibly pregnant
- ☐ Currently breastfeeding

Musculoskeletal
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Joint swelling
- ☐ Red, hot, tender joints
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle pain

Skin/Breast
- ☐ Acne
- ☐ Changing/new moles
- ☐ Dry skin
- ☐ Nail changes
- ☐ Jaundice

Skin/Breast (continued)
- ☐ Itching
- ☐ Rash
- ☐ Warts
- ☐ Breast lump
- ☐ Breast skin changes
- ☐ Breast tenderness
- ☐ Nipple discharge

Neurologic
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Memory loss
- ☐ Numbness/tingling
- ☐ Seizures/convulsions
- ☐ Tremors
- ☐ Vertigo
- ☐ Weakness

Hematologic/Lymphatic
- ☐ Excessive bleeding
- ☐ Increased bleeding
- ☐ History of blood transfusion
- ☐ Enlarged lymph nodes/glands

Endocrine
- ☐ Enlarging hands/feet
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive hair growth
- ☐ Hot flashes
- ☐ Increased skin pigmentation
- ☐ Infertility
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Excessive hunger

Allergic/Immunologic
- ☐ Allergies/hayfever
- ☐ Hives
- ☐ Frequent colds/sinus infections
- ☐ Immune system disorder

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Crying spells
- ☐ Mood swings
- ☐ Feeling stressed
- ☐ Loss of interest in pleasurable activities
- ☐ Sadness
- ☐ Poor concentration
- ☐ Difficulty sleeping
- ☐ Sleeping too much
- ☐ Thoughts of suicide

Name: _____ Date: _____ Date of Birth: _____

Medication list

Name of Medication	Dosage	Directions

Other providers participating in your healthcare

Name of Provider	Specialty of Provider	Type of Care	Date of Last Visit
	Eye Doctor, if applicable		
	Dentist, if applicable		
	Gynecologist, if applicable		

Hospitalizations within last three years

Reason for Hospital Visit	Facility	Attending Physician	Date

Do you have any health improvement opportunities or medical concerns you would like to address? _____
_____
_____
_____