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 annually 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 and depression
- 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**. Please ensure that you provide a COMPLETE list of ALL medications and supplements. Please ensure that you provide a COMPLETE list of all other medical providers participating in your care. ***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. 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.*

Thank you for actively participating in your healthcare and taking the time to provide this detailed information that will allow us to provide this comprehensive service as efficiently as possible

Warmest regards,

Adam A. Brunson, MD

Bonnie Davis, APRN

Name: _____ Date of Birth: _____ Today's Date: _____

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. 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

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

4. How many times in the last 6 months have you been to the emergency room?
   - ❑ 0
   - ❑ 1-2
   - ❑ 3-4
   - ❑ 5+
   - ❑ I don't know

5. How many times in the last 6 months were you admitted to the hospital?
   - ❑ 0
   - ❑ 1-2
   - ❑ 3-4
   - ❑ 5+
   - ❑ I don't know

Physical Activity

6. Do you usually get at least 150 minutes of moderate aerobic activity (like brisk walking) or 75 minutes of vigorous aerobic activity (like jogging) per week?
   - ❑ Yes
   - ❑ No
   - ❑ I do not exercise

7. Do you do strength training exercises for all major muscle groups at least two times per week?
   - ❑ Yes
   - ❑ No
   - ❑ I do not exercise

Nutrition

8. Do you usually eat a diet that has at least 4 servings of fruit and vegetables, includes fiber/whole grains and avoids (other than occasional servings) high fat foods and sweets?
   - ❑ yes ❑ no

9. On a typical day, how many sugar-sweetened drinks do you drink?
   _____ drinks per day

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

Oral Health

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

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

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Functional Status

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

14. Do you have any vision problems?
    ❑ yes ❑ no

15. Do you or your family have any concerns about your memory?
    ❑ yes ❑ no

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

Safety Screening

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

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

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

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

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

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

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

24. 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

Social History

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

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

27. Think about your drinking in the past year. A drink means 12 oz. of beer, 5 oz. of wine or 1.5 oz. of 80 proof liquor.
    a. How often do you have a drink containing alcohol?
    ❑ Daily
    ❑ 4-6 times per week
    ❑ 2-3 times per week
    ❑ Weekly
    ❑ Monthly
    ❑ Less than monthly
    ❑ Never

    b. How many drinks containing alcohol do you consume on a typical day you are drinking?
    ❑ 10 or more
    ❑ 7-9
    ❑ 5-6
    ❑ 4
    ❑ 3
    ❑ 2
    ❑ 1

    c. How often do you have (5 for men; 4 for women & men over age 65) or more drinks on one occasion?
    ❑ Daily
    ❑ 4-6 times per week
    ❑ 2-3 times per week
    ❑ Weekly
    ❑ Monthly
    ❑ Less than monthly
    ❑ Never

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28. In the past year, have you used an illegal drug or used a prescription medication for nonmedical reasons?
    - ❑ yes ❑ no

Mental Health

29. 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

30. 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

31. 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

32. 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

End of life planning

33. Do you have any of the following advance directives?
    - ❑ Living will/advance directive
    - ❑ Do not resuscitate order
    - ❑ Durable power of attorney
    - ❑ Health care proxy
    - ❑ No formal document

34. Have you discussed your end of life wishes with your family?
    - ❑ yes ❑ no

35. Would you like more information on advance directives?
    - ❑ yes ❑ no

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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 of Birth: _____ Today's Date: _____

Medication list

Name of Medication	Dosage	Directions

Hospitalizations within last three years

Reason for Hospital Visit	Facility	Attending Physician	Date

Do you have any specific medical concerns that you would like to address? Please note that these concerns will likely require a separate office visit to appropriately evaluate and treat.

_____

_____

_____

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Other providers participating in your healthcare

Please help us ensure that our office has all treating providers current in your chart. Please provide first and last name of doctors or nurse practitioners below. Simply write NA if you do not treat with someone in the specialty listed below.

Primary Care Physician: _____ Date of last visit: _____

Allergist: _____ Date of last visit: _____

Cardiologist: _____ Date of last visit: _____

Chiropractor: _____ Date of last visit: _____

Dentist: _____ Date of last visit: _____

Dermatologist: _____ Date of last visit: _____

Endocrinologist: _____ Date of last visit: _____

ENT: _____ Date of last visit: _____

Gastroenterologist: _____ Date of last visit: _____

Gynecologist: _____ Date of last visit: _____

Nephrologist: _____ Date of last visit: _____

Neurologist: _____ Date of last visit: _____

Oncologist: _____ Date of last visit: _____

Ophthalmologist (Eye): _____ Date of last visit: _____

Orthopedic Surgeon: _____ Date of last visit: _____

Pain Management: _____ Date of last visit: _____

Psychiatrist: _____ Date of last visit: _____

Psychologist: _____ Date of last visit: _____

Pulmonologist: _____ Date of last visit: _____

Rheumatologist: _____ Date of last visit: _____

Sleep Doctor: _____ Date of last visit: _____

Urologist: _____ Date of last visit: _____

_____: _____ Date of last visit: _____

_____: _____ Date of last visit: _____