# Age 22-64 *Wellness Visit*

*(previously known as Physical or Annual Checkup)*

We want you to receive wellness care – health care that may lower your risk of illness or injury.

Why Wellness:

- An ANNUAL wellness visit is covered by nearly all insurance plans to focus on wellness and preventive care.
- There is no deductible or co-pay for most insurance carriers for this visit.
- Most plans also cover testing recommended by the US Preventive Services Task Force for categories A and B services.
- Check with your insurance carrier for the specific benefits of your plan.

What is included:

- Health Risk Appraisal (attached questionnaire)
- Height, weight, and BP measurements – calculation of BMI
- Review of your medical and family history
- Physical exam dependent on age group and risk factors
- **Written plan** letting you know what screenings, shots, and other preventive services you need

**A wellness visit does not deal with new or existing health problems**. Please let our scheduling staff know if you need the doctor's help with a health problem, a medication refill or other questions so a separate visit can be scheduled.

**<u>WHAT YOU NEED TO DO – Checklist:</u>**

- ☐ Complete the attached form as completely as possible
- ☐ A snapshot of your health record is attached. Please review and indicate any missing or incorrect information
- ☐ Bring this form to your WELLNESS appointment – and give to the nurse when you are checked into the exam room
- ☐ Bring your medication bottles with you as we need to verify ALL medications that you are taking

**Your WELLNESS visit is scheduled:** ________________________________ @ __________ AM/PM

**We look forward to partnering with you to improve your health!**

11/8/18

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# Well-Care Questionnaire – 

**for adults aged 22-64**

| Name | Chart# | D.O.B. | Date |
|---|---|---|---|
| | | | |

## FAMILY HISTORY – please ✓to indicate positive history

| | Father | Mother | Brother | Sister | Uncle | Aunt | Son | Daughter | Other |
|---|---|---|---|---|---|---|---|---|---|
| Deceased | | | | | | | | | |
| Diabetes | | | | | | | | | |
| High blood pressure | | | | | | | | | |
| Heart disease | | | | | | | | | |
| Stroke | | | | | | | | | |
| Kidney disease | | | | | | | | | |
| Liver disease | | | | | | | | | |
| Colon/rectal cancer | | | | | | | | | |
| Breast cancer | | | | | | | | | |
| Prostate cancer | | | | | | | | | |
| Other cancer | | | | | | | | | |

Current or Usual Occupation:

Others living in your home (name, age, relationship):

How would you describe your general health? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

What sports, activities or hobbies are you involved?

On average, how many **days** per week do you do moderate-strenuous exercise like a brisk walk or jog?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ don't know

On average, how many **minutes** do you exercise at this level each day? _______________

**Do you eat:** Fruits and vegetables every day? ☐ Yes ☐ **No**
Do you eat/drink dairy products? ☐ Yes ☐ **No**
Are you a vegetarian? ☐ **Yes** ☐ No
Do you have any questions or concerns about eating habits? ☐ **Yes** ☐ No

If you ride motorcycle or bicycle, do you always wear a helmet? ☐ Yes ☐ **No**
Do you always use your seatbelt when in a car? ☐ Yes ☐ **No**
Do you text while driving? ☐ **Yes** ☐ No
DO you ever drive under the influence of alcohol or drugs, or ride with a driver who is? ☐ **Yes** ☐ No

Ever been a victim of threats, physical hurting, or forced sexual contact? ☐ **Yes** ☐ No

During the past year, have you had any major changes in your life, good or bad? ☐ No ☐ **Yes**
If **YES**, please explain

Over the last 2 weeks, how often have you been bothered by little or no interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than ½ of days ☐ Most days

Over the last 2 weeks, how often you have been bothered by feeing down, depressed, or hopeless?
☐ Not at all ☐ Several days ☐ More than ½ of days ☐ Most days

A score of 2 or 3 on either question: use PHQ-9

| | |
|---|---|
| How often did you have one drink containing alcohol in the last year?<br>☐ Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/wk ☐ 4 or more times/wk<br>How many drinks containing alcohol did you have on a typical day when you are drinking in the last year? ☐ I don't drink alcohol ☐1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more<br>How often did you have 6 drinks or more on one occasion in the last year?<br>☐ Never ☐ less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily | If > 3 for women or > 4 for men – recommend brief intervention |
| In the last 12 months, have you used drugs other than those required for medical reasons? ☐ **Yes** ☐ No | If yes, use DAST-10 |
| Have you ever used tobacco (smoke, chew, or e-cigarettes) or vapor product ☐ Yes – but quit in year ________ ☐ Yes use now ☐ Never | |
| Have you had sex with: ☐ Man ☐ Woman ☐ Both ☐ Never had sex<br>Have you been tested for HIV? ☐ Yes ☐ No<br>Are current sexual partners known to be HIV positive: ☐ **Yes** ☐ No<br>Have you had sex with a new partner(s) since your last visit? ☐ **Yes** ☐ No<br>If YES, did you use condoms? ☐ Always ☐ **Sometimes** ☐ **Never** | |

## For Women – men jump ahead to RISK FACTORS

If you have sex with a male partner, do either of you use protection from pregnancy?
☐ **Yes** ☐ No ☐ Doesn't apply to me

If YES, what kind of protection?
☐ Condoms ☐ Birth control pills ☐ IUD ☐ DepoProvera ☐ Other ________________________
Surgical Method: ☐ Tubal ☐ Partner has vasectomy ☐ Hysterectomy

Do you plan to get pregnant in the next year? ☐ Yes ☐ No

If you're still menstruating, when was your last period (date):
☐ Had hysterectomy ☐ Menopause ☐ On contraception that prevents periods
If you're still menstruating, please describe your periods:
☐ Tubal ☐ Partner has vasectomy ☐ Hysterectomy ☐ Painful ☐ Absent ☐ Doesn't apply to me

Is urination or leaking urine a problem for you? ☐ **Yes** ☐ No

| | | | |
|---|---|---|---|
| 1. Do/did you have a mother/sister/daughter with breast or ovarian cancer? | ☐ **Yes** | ☐ No | Refer for BRCA testing/genetic counseling for any YES answer |
| 2. Any relative with BILATERAL breast cancer? | ☐ **Yes** | ☐ No | |
| 3. Any man in your family have breast cancer? | ☐ **Yes** | ☐ No | |
| 4. Any woman in your family have BOTH breast and ovarian cancer? | ☐ **Yes** | ☐ No | |
| 5. Any woman in your family have breast cancer before age 50? | ☐ **Yes** | ☐ No | |
| 6. Do you have 2 or more relatives with breast and/or ovarian cancer? | ☐ **Yes** | ☐ No | |
| 7. Do you have 2 or more relatives with breast and/or bowel cancer? | ☐ **Yes** | ☐ No | |

**For women who are pregnant or might become pregnant**

Are you taking a daily supplement that has folate (folic acid)? ☐ Yes ☐ **No**

**For women after menopause**

| | | |
|---|---|---|
| Are you taking a daily supplement that has both Vitamin D and calcium? | ☐ Yes | ☐ **No** |
| Have you had any bleeding since you stopped having your periods? | ☐ **Yes** | ☐ No |
| Do you have pain with intercourse? | ☐ **Yes** | ☐ No |

| **RISK FACTORS** – to help determine if other tests/evaluations may be needed, PLEASE answer the following | | |
|---|---|---|
| **Condition** | **Risk Factors** | **Do you have any of the listed risk factors?** |
| HIV | Men who have sex with men<br>Injection drug user<br>Having unprotected vaginal or anal intercourse<br>Having sexual partners who are HIV-infected, bisexual, or injection drug user<br>Exchanging sex for drugs or money | Yes / No |
| Syphilis | Men who have sex with men<br>Man/woman with HIV infection'<br>Ever been incarcerated in prison<br>Exchanging sex for drugs or money | Yes / No |
| Hepatitis B | Born in country/region with high prevalence<br>US born person not vaccinated as infant – whose parents born in hi-risk country<br>HIV positive person<br>Injection drug user<br>Men who have sex with men<br>Household contacts or sexual partners of persons with hepatitis B infection | Yes / No |
| Hepatitis C | Born 1945-1965<br>Past or current injection drug use<br>Receipt of blood transfusion before 1992<br>Long-term hemodialysis<br>Born to hepatitis C infected mother<br>Ever been incarcerated in prison<br>Intranasal drug use<br>Unregulated tattoo<br>Multiple sex partners, unprotected sex<br>Sex with hep-C infected person or injection drug user | Yes / No |
| Latent TB | Born in or former resident in high risk country/region (Mexico, Philippines, Vietnam, India, China, Haiti, and Guatemala)<br>Live in or have lived in high-risk congregate settings (homeless shelter/prison) | Yes / No |

| **PREVENTIVE MEASURES you have had:** | | | |
|---|---|---|---|
| ***Procedure/Test*** | ***Date of last*** | ***Where received?*** | ***Ever had abnormality?*** |
| PAP test | ☐ never | | ☐ never ☐ yes |

| ***IMMUNIZATIONS*** | ***Date of last*** | ***Where received?*** |
|---|---|---|
| Tetanus | | |
| Tetanus w/whooping cough | | |
| MMR | | |
| Hepatitis B | | |
| Varicella | | |

**Is there anything about your health that we didn't cover that we should know?**

Signature: Date: