WELLNESS EXAMINATION

NAME ______________________________ DATE ________________

Personal Medical History
List Your Current Medical Conditions:

List and Date Your Prior Hospitalizations:

List and Date Your Prior Operations:

Family History
List the Medical Conditions Present in Your Immediate Family Members

Providers and Suppliers
List all physicians, home health services, medical equipment providers involved in your care. For each physician, list their specialty, last visit date, and next visit date

Medications
Provide a list of all your current medications (prescription and nonprescription) and dosages for each

Supplies
Provide a list of all supplies which you regularly use, such as cane, walker, wheelchair, diabetic supplies, wound supplies, oxygen

Allergies
Provide of a list of all your medication allergies or intolerances and a list of all environmental allergies

General Questions

1) Have you smoked cigarettes or used other tobacco products during the past year?
What is your current usage?

2) Have you wanted to reduce your alcohol or drug usage during the past year?
What is your current usage?

3) Do you have a living will or advance directive?

4) Do you have recent feelings of depression, hopelessness, or suicidal thoughts?

5) Do you have little interest or lack of pleasure in doing things or being social?

6) Do you need help with transportation, meal preparation, household chores, taking your medications on schedule, or assistance with managing your finances?

7) Have you fallen down during the past year?

8) Does you home lack adequate lighting, railings, or handicap provisions?

9) Do you have impairment of your memory?
Give examples of how this affects your daily activities.

10) Do you have impairment of your hearing?
If so, how has it been treated?

11) Are you up to date with visitation to your eye doctor? Are you satisfied with your current level of vision?

12) Are you up to date with your visitation to your dentist?

Medical Testing

Please Indicate Whether You Have Had These Procedures, The Date, and Next Due Date

	Date	Next Due Date
Mammography	________________	_________________
Colonoscopy	________________	_________________
Cholesterol Screening	________________	_________________
Diabetes Screening	_________________	_________________
Prostate/PSA Exam	_________________	_________________
Pelvic/Pap Test	_________________	_________________
Bone Density Test	_________________	_________________
Abdominal Aneurysm Ultrasound	_________________	_________________
Eye/Glaucoma Exam	_________________	__________________
Medical Nutrition Counseling	_________________	__________________
Immunizations		
flushot	__________________	
pneumonia vaccine	__________________	
shingles vaccine	__________________	

Patient Signature __________________ Date ___________________

Physician Signature ________________ Date ___________________