Annual Wellness Review

Patient Name ______________________________________ DOB ____________

Medical History Review	**Circle one**		
Have there been any changes to your family medical history in the past year?	Yes	No	
Have you had any surgeries or hospitalizations in the past year?	Yes	No	
Are you treated regularly by another doctor?	Yes	No	
Have you had a change in your ability to take care of yourself in the past 3 months?	Yes	No	
Have you fallen in the last year?	Yes	No	
Do you experience hearing loss or fluctuation in your hearing?	Yes	No	
Do you struggle to hear conversations?	Yes	No	
Do you need to turn up the TV to be able to hear?	Yes	No	
Do you or your family have concerns about your memory?	Yes	No	
Do you experience urinary incontinence (leaking of urine)?	Yes	No	
If yes, how much does it impact your quality of life?	Not at all	Some	A lot

Daily Activities Review

Do you need help with any of the following daily activities? (Select all that apply)

☐ Eating	☐ Dressing	☐ Bathing
☐ Toileting	☐ Walking	☐ Paying bills/finances
☐ Managing medications	☐ Shopping	☐ Food preparation
☐ Household Chores	☐ No help needed	

If you marked yes to any of the above, who helps you? ____________________________________

Are you able to drive?	Yes	No
Do you ever worry you will run out of food before you get money for more?	Yes	No
Do you have trouble paying your utility bills?	Yes	No

Safety

Do you have stairs?	Yes	No
If yes, do your stairs have handrails?	Yes	No
Do you have throw rugs, slippery or unsafe flooring in your home?	Yes	No
Do you have grab bars in the bathroom/shower/tub?	Yes	No
Does your home have smoke detectors?	Yes	No
Do you have guns or weapons in your home?	Yes	No
If yes, are they locked up?	Yes	No
Do you fear for your personal safety in your own home?	Yes	No
Have you been pushed, hit or threatened in your own home?	Yes	No

Do you have a POLST (Physician's Order for Life Sustaining Treatment), Living Will, or Advance Directive?	Yes	No
If no, would you like to discuss these options?	Yes	No