Annual Wellness Visit

HealthCare Partners

This form can be used to document your patients' Annual Wellness Visits (AWV). Required steps and helpful tips have been included to aid in the process. All applicable fields must be addressed for the exam to be considered complete. Please submit the completed form no later than 7 days from the DOS.

Patient Name: _____ DOB: ___ /___ /_____ Date of Service: ___ /___ /_____

Age: ___ Sex: ___ Patient Phone: _____

Provider: _____ Provider Phone: _____

Emergency Contact Name/Number: _____ Marital Status: _____

Preferred language: _____ MRN#: _____

Any language or communication barriers? Yes ___ No ___

LOCATION OF VISIT

Provider Office ___ Home Setting ___ (PCP ___ /Vendor ___) Skilled Nursing Facility ___

Group Home ___ Audio & Video ___

MODALITY

In Person ___ Telehealth ___

HEALTH STATUS

How do you feel today? (Select one) Feels Well ___ Feels Better ___ Feels Worse ___

Health Concerns: _____

VITAL SIGNS

Weight: _____ Height: _____ Temp: _____ Pulse rate: _____ BP: _____

BMI *(Formula: 703 x weight (lbs) / [height (in)]^2)*: _____

(Refer for assessment with PCP if BMI is less than 18 or greater than 30)

Patient Name: _____ DOB: ___ /___ /_____ Date of Service: ___ /___ /_____

PHYSICAL EXAM

	WNL	ABN	Comments
HEENT			
NECK			
RESPIRATORY			
ENDOCRINE			
HEMA/LYMPH			
CHEST			
BREAST			
CVS			
ABDOMINAL			
MUSKULOSKELETAL			
EXTREMITIES			
NEUROLOGOCAL			
INTEGUMENTARY			

PAIN ASSESSMENT

Notate with a check mark the number listed below that best describes the pain level:

Describe type of pain and location:

Patient Name: _____ DOB: ___ /___ /_____ Date of Service: ___ /___ /_____

FUNCTIONAL ASSESSMENT

Please indicate "1" or "0" in score field for each activity and whether patient has been counseled. Please add scores in the space provided for the Total Functional Score.

Activity	Score	Comments
CONTINENCE 0 = incontinent (or catheterized & unable to manage alone) 1 = independent		
MOBILITY/TRANSFERRING 0 = unable; help needed in moving from bed to chair or requires complete transfer; uses wheelchair 1 = moves in & out of bed unassisted (mechanical aids are acceptable)		
FEEDING 0 = needs partial or total help with feeding or requires parenteral feeding 1 = gets food from plate into mouth independently; prep of food may be done by another person		
BATHING 0 = needs help with bathing or getting in & out of the shower 1 = independent (bathes self completely; disabled extremity)		
DRESSING 0 = needs help with dressing self or needs to be completely dressed 1 = gets clothes from closet & puts on clothes complete with fasteners		
TOILET USE 0 = needs help transferring to the toilet; unable to clean self; uses bed pan or commode 1 = goes to toilet, gets on & off, cleans genital area without help		
WALKING 0 = needs help from another person with walking or completely unable to walk 1 = independent; able to walk by themselves or with cane or other assistive devices		
Total Functional Score		

HOME SAFETY/ASSISTANCE

Do you feel safe in your current home? Yes ___ No ___

If no, why not?

How many times have you fallen in your home?

Never

Once ___

A few times ___

Many times ___

How much would you need to change your living circumstances to feel safe?

Not at all ___

A little ___

Quite a bit ___

A significant amount ___

What would you like to change?

Do you feel that living somewhere else would be good for you? Yes ___ No ___

How much help do you feel you need at home?

None ___

A little ___

Quite a bit ___

Daily assistance ___

Who is your primary caregiver?

Name: _____

Relationship: _____

How much does your caregiver help with daily or routine chores?

Not Applicable ___

None ___

A little ___

Quite a bit ___

A significant amount ___

Do you need help to go and see your doctors? Yes ___ No ___

What kind of help do you need?

ASSESSMENT OF NUTRITION

Do you feel that you are you well nourished? Yes ___ No ___

Not assessed ___ *(Refer for assessment with PCP)*

Do you take any vitamin or mineral supplements? Yes ___ No ___

Are you on aspirin? Yes ___ No ___

If no, why not? _____

Patient Name: _____ DOB: ___ /___ /_____ Date of Service: ___ /___ /_____

VISION AND HEARING SCREENING

Do you have issues with your sight? Yes ___ No ___

Do you wear glasses? Yes ___ No ___

Do you have hearing difficulty? Yes ___ No ___

Do you have a hearing aid? Yes ___ No ___

DENTAL

Have you had your annual dental exam? Yes ___ No ___

Do you wear dentures? Yes ___ No ___

FALL RISK SCREENING

Any falls in the past year? Yes ___ No ___

Have you fallen more than one time in last 12 months? Yes ___ No ___ N/A ___

Did you ever have a fall evaluation? Yes ___ No ___

If no, why not? _____

If yes, why and when? _____

Are you having trouble walking or with your balance? Yes ___ No ___

Do you use any assistive device? Yes ___ No ___

Are you on blood thinners? Yes ___ No ___

BONE HEALTH

Have you ever been evaluated for bone health? Yes ___ No ___

Have you ever been told that you have thin or brittle bones? Yes ___ No ___

Have you been diagnosed with Osteopenia or Osteoporosis? Yes ___ No ___

Have you been referred to a provider to treat Osteopenia or Osteoporosis? Yes ___ No ___

If no, why not? _____

Have you been prescribed Vitamin D, Calcium or any other bone strengthening medication? Yes ___ No ___

FRAILITY ASSESSMENT

Check all that apply, 3 or more "yes" responses are suggestive of frailty. Refer to PCP/Neurology or BH.

Have you experienced the following?

- Unintentional weight loss Yes ___ No ___
- Feeling of exhaustion (even at rest) Yes ___ No ___
- Weakness Yes ___ No ___
- Slow walking speed Yes ___ No ___
- Low level of physical activity Yes ___ No ___

COGNITIVE FUNCTION SCREENING

Check all that apply, 3 or more "yes" responses are suggestive of cognitive decline. Refer to PCP/Neurology or BH.

Have you experienced the following?

- Asking the same questions repeatedly? Yes ___ No ___
- Forgetting appointments and important events? Yes ___ No ___
- Forgetting common words when speaking? Yes ___ No ___
- Having trouble coming up with words that one commonly knows? Yes ___ No ___
- Losing train of thoughts in conversations, movies or books? Yes ___ No ___
- Mixing words up? Yes ___ No ___
- Taking longer to complete a familiar task? Yes ___ No ___
- Misplacing items frequently? Yes ___ No ___
- Increased irritability and / or anxiety? Yes ___ No ___

Do you have hypothyroidism? Yes ___ No ___

If yes, are you on replacement therapy? Yes ___ No ___

Do you use any brain slowing medications (sedatives, hypnotics, antipsychotics)?

Yes ___ No ___ *(Give appropriate referrals)*

Are you using any illicit drugs? Yes ___ No ___ If so which one(s)? _____ *(Refer to BH)*

Do you have sleep deprivation or obstructive sleep apnea? Yes ___ No ___ *(Refer to PCP)*

Patient Name: _____ DOB: ___ /___ /_____ Date of Service: ___ /___ /_____

DEPRESSION SCREENING - Patient Health Questionnaire (PHQ – 9)

If the answer to questions 1 and 2 is "0/Not at all", the survey is complete.
Please indicate N/A if this section cannot be administered for any reason and provide reason below.

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly Everyday	N/A
1. Little interest or pleasure in doing things					
2. Feeling down, depressed, or hopeless					
3. Trouble falling or staying asleep, or sleeping too much					
4. Feeling tired or having little energy					
5. Poor appetite or overeating					
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down					
7. Trouble concentrating on things, such as reading the newspaper or watching television					
8. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual					
9. Thoughts that you would be better off dead, or hurting yourself					
Scoring					
Total Score					

For scores higher than 0, how difficult have those problems made it for you to do work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely Difficult

Select the appropriate score: Minimal Depression (1-4); Mild Depression (5-9); Moderate Depression (10-14); Moderately Severe Depression (15-19); Severe Depression (20-27)

Additional Comments:

Patient Name: _____ DOB: ___ /___ /_____ Date of Service: ___ /___ /_____

SUBSTANCE USE DISORDER SCREENING

Alcohol

Never ___

Once or twice ___

Monthly ___

Weekly ___

Daily/Almost Daily ___

How many drinks per week? ___

Tobacco Products

Never ___

Once or twice ___

Monthly ___

Weekly ___

Daily/Almost Daily ___

How many packs per week/how long? ___

Prescription drugs for non-medical reasons

Never ___

Once or twice ___

Monthly ___

Weekly ___

Daily/Almost Daily ___

Illicit Drugs

Never ___

Less than monthly ___

Monthly ___

Weekly ___

2-3 times a week ___

4-6 times a week ___

Daily ___

Referral to Behavioral Health made? *(For In Office use only)* Yes ___ No ___

If no, why not? _____

IMMUNIZATION STATUS

Have you received the following vaccines?

	Date
Influenza	
Pneumonia	
Hepatitis B	
Tetanus	
COVID (first dose)	
COVID (second dose)	
COVID (Booster)	
Shingles	

MEDICATION LIST

Reviewed medication list with patient (prescriptions and non-prescriptions —including OTC, vitamins, home remedies and herbs) and updated.

Active Medication	Treatment for/Prescribed by	Dose/Frequency

COMMENTS: *(A separate medication list may be attached if needed and must include the patient's name, DOB, DOS and provider signature.)*

Patient does not take any medications: _____ Date: ___/___ /_____

ALLERGIES OR REACTIONS TO MEDICATIONS: *Reviewed patient-completed list of allergies with patient. Significant findings and/or changes were noted on patient's allergy list and include:*

ADVANCE CARE PLANNING

Do you have any Advanced Directives in place? Yes ___ No ___

Does HCP/MD have a copy on file? Yes ___ No ___

Which do you have in place?

- Living Will
- Healthcare Proxy ___
- Power of Attorney for Healthcare ___
- DNR (Do Not Resuscitate) ___
- DNI (Do Not Intubate) ___
- Comfort Care ___
- None ___

If no, why not?

Would you like more information on Advanced Directives? Yes ___ No ___

Patient Name: _____ DOB: ___ /___ /_____ Date of Service: ___ /___ /_____

ASSESSMENT AND TREATMENT PLAN

Active Diagnosis	Status	Treatment Plan
	Indicate the status of assessed diagnosis: Worsening Improving Stable Provider:	
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Other Conditions				
Description	**Active**	**Status (if active, check one)**	**Not Present**	**Inconclusive**
		☐ Stable ☐ Improving ☐ Worsening		
		☐ Stable ☐ Improving ☐ Worsening		
		☐ Stable ☐ Improving ☐ Worsening		

Patient Name: _____ DOB: ___ /___ /_____ Date of Service: ___ /___ /_____

COMPLETED BY

Provider Name: _____ Provider Signature*: _____

Credentials*: MD___ DO___ NP___ PA___ Provider NPI Number*: _____

Date: ___ /___ /_____ Clinical or Vendor Name: _____ Phone: _____