# DESERT EDGE MEDICAL

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

## ANNUAL WELLNESS VISIT ASSESSMENT

To help us understand your overall well-being, we gather important information about your health at each appointment. Thank you for answering these questions in preparation for your visit!

### 1. How would you rate your overall health? (Check one)

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

### 2. Please answer YES or NO to the following:

| | | | |
|---|---|---|---|
| A. | Are you feeling increased stress? | ☐ Yes | ☐ No |
| B. | Are you experiencing Social Isolation? | ☐ Yes | ☐ No |
| C. | Are you a current smoker? | ☐ Yes | ☐ No |
| D. | Are you exposed to second-hand smoke? | ☐ Yes | ☐ No |
| E. | Do you lack a balanced diet? | ☐ Yes | ☐ No |
| F. | Is your access to food/nutrition **inadequate?** | ☐ Yes | ☐ No |
| G. | Do you drink 4 or more alcoholic drinks in a day? | ☐ Yes | ☐ No |
| H. | Do you engage in recreational drug use? | ☐ Yes | ☐ No |

### 3. Are you able to bathe, walk, and use the toilet without assistance? (Check all that apply)

☐ Yes ☐ No

If No, which activities require assistance? (Please check all that apply)

☐ Bathing ☐ Walking ☐ Using Toilet

### 4. Are you able to go shopping, do housekeeping, handle finances, and take medications w/o assistance?

☐ Yes ☐ No

If No, which activities require assistance? (Please check all that apply)

☐ Shopping ☐ Housekeeping ☐ Handling Finances ☐ Taking Medications

OFFICE USE ONLY: Scanned____Entered____

**5. Does someone help you at home? (Check all that apply)**

☐ Yes ☐ No

If Yes, please provide Caregiver Name.

☐ Spouse:_____ ☐ Children:_____ ☐ Other:_____

**6. How often do you exercise for at least 20 minutes 3 or more time a week? (Check one)**

☐ Most of the time ☐ Some of the time ☐ Less Frequently ☐ Not at all

**7. Have you fallen in the last year?**

☐ Yes ☐ No

**8. Do you feel unsteady when standing or walking?**

☐ Yes ☐ No

If Yes, which of these assistive devices do you use? (Please check all that apply)

☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches

☐ Other:_____ ☐ None

**9. Over the past 2 weeks, how often have you been bothered by any of the following problems? (Check one)**

| | Not at all | Several days | More than half days | Nearly every day |
|---|---|---|---|---|
| Little interest or pleasure in doing things. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feeling down, depressed, or hopeless. | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

****NOTE: If you checked 1 or higher on either question there is an additional form for you to fill out. Please let the front desk know if you need one.**

**10. During the past 12 months, how often has confusion or memory loss interfered with your ability to work, volunteer, or engage in social activities?**

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

**11. Do you have any problems with your vision? (Check all that apply)**

☐ No vision problems ☐ Wear Glasses/Contacts ☐ Legally Blind ☐ Assistance needed with vision problems

☐ Other:_____

**12. Do you have any problems with your hearing? (Check all that apply)**

☐ No problems ☐ Partial Loss ☐ Deaf ☐ TTY Used ☐ Assistance needed with hearing problems

☐ Use assistive devices:_____ ☐ Other:_____

**13.Does your family or friends know what you want in an emergency situation or if you could not speak for yourself? (If you have any of the following, it would be helpful to have a copy provided to us for your medical record)**

☐ Yes, I have a **living will**

☐ Yes, I have a **Power of Attorney**

☐ Yes, I have a **MOLST** (Medical Orders for Life-Sustaining Treatment)

☐ Yes, I have a **POLST** (Provider Orders for Life-Sustaining Treatment)

☐ Yes, I have **completed 5 wishes**

☐ No, but I am interested

☐ **No**, and I do want one at this time

**14. Please list current medical providers. (This includes all specialists)**

| Provider | Specialty |
|---|---|
| | |
| | |
| | |
| | |
| | |

**15. Personal Preventive Plan Services (PPPS) Check each item that has been done and enter the date (Mo./Yr.) when it was last done:**

**VACCINATIONS & IMMUNIZATIONS**

Flu Shot

☐ Yes:_____ ☐ No

COVID-19 Vaccine

☐ Yes:_____ ☐ No

Pneumonia Shot

☐ Yes:_____ ☐ No

Tetanus Shot

☐ Yes:_____ ☐ No

Zoster-Shingles

☐ Yes:_____ ☐ No

**DIABETIC REVIEW:**

Retinal Eye Exam

☐ Yes:_____ ☐ No

Diabetic Foot Exam

☐ Yes:_____ ☐ No

Urinalysis - Creatinine/Albumin

☐ Yes:_____ ☐ No

Hemoglobin A1C

☐ Yes:_____ ☐ No

**SCREENINGS:**

Bone Density Scan

☐ Yes:_____ ☐ No

Colonoscopy

☐ Yes:_____ ☐ No

AAA Screening (Abdominal Aortic Aneurysm)

☐ Yes:_____ ☐ No

Eye Exam

☐ Yes:_____ ☐ No

**WOMEN ONLY:**

Mammogram

☐ Yes:_____ ☐ No

Pap Smear

☐ Yes:_____ ☐ No

**MEN ONLY:**

Prostate-specific antigen (PSA - Blood Test

☐ Yes:_____ ☐ No