PATIENT NAME: _____ **DATE:** _____

DOB: _____

Annual Wellness Visit Self-Assessment Form

FALLS RISK

1	Have you fallen two or more times in the past year?	**YES**	**NO**	
	If yes were you injured?	**YES**	**NO**	
2	Do you have difficulty with dizziness or problems with balance?	**YES**	**NO**	
3	Do you avoid doing things due to the fear of falling?	**YES**	**NO**	
4	Do you have things in your house which might cause you to fall?	**YES**	**NO**	

PHYSICAL ACTIVITY AND PAIN

1	How often does physical/emotional health interfere with your daily activities?	**Frequently**	**Occasionally**	**Almost never**
2	How often do you take the escalator over the stairs?	**Frequently**	**Occasionally**	**Almost Never**
3	How often does pain interfere with your normal activities?	**Frequently**	**Occasionally**	**Almost never**
4	How much pain do you have on a daily basis?	**0 1 2 3 4 5 6 7 8 9 10**		
	If you do have daily pain, where is the pain located? _____			
5	Approximately how many days each week are you physically active?	**0-1 days**	**2-3 days**	**4 or more**
6	How many days a week do you exercise?	**0-1 days**	**2-3 days**	**4 or more**
7	How many hours of sleep do you usually get each night?	**5 or less hours**	**6-7 hours**	**8 or more hours**

ACTIVITIES OF DAILY LIVING

1	Can you eat, bathe, get dressed, get around your home without help?	**YES**	**NO**	
2	Are you able to prepare your own meals?	**YES**	**NO**	
3	Are you able to do your own housekeeping without help?	**YES**	**NO**	
4	Are you able to shop without help?	**YES**	**NO**	
5	Can you handle your own money without help?	**YES**	**NO**	
6	Are you able to travel independently by bus or taxi?	**YES**	**NO**	
7	Do you have enough help at home with your care or doing chores?	**YES**	**NO**	
8	Do you drive a car?	**YES**	**NO**	
	If yes: do you have any difficulty driving?	**None**	**Some Difficulty**	**Very Difficult**

OTHER HEALTH ISSUES

1	When was your last dilated eye exam? _____			
	Name of your eye doctor: _____			
2	Do you have problems with your hearing?	**YES**	**NO**	
3	Do you have problems with your memory?	**YES**	**NO**	
4	Do you have trouble eating well?	**YES**	**NO**	
5	Do you have trouble with your teeth or dentures?	**YES**	**NO**	
6	Do you have a Living Will?	**YES**	**NO**	
	If yes, have you given us a copy?	**YES**	**NO**	
7	Did you get a flu shot this year?	**YES**	**NO**	
	If not do you want one?	**YES**	**NO**	

PLEASE TURN PAGE OVER

PATIENT NAME: _____ **DATE:** _____

DOB: _____

Annual Wellness Visit Self-Assessment Form

BLADDER CONTROL

1	Is leaking of urine a problem for you?	**YES**	**NO**	**N/A**
2	Has urine leakage changed your activities or interfered with sleep?	**YES**	**NO**	**N/A**
3	If urine leakage is a problem for you, would you be willing to try:			
	Medications	**YES**	**NO**	
	Bladder Training Exercises	**YES**	**NO**	
	Surgery	**YES**	**NO**	

MEDICATIONS

Remembering to take your medications can sometimes be challenging.

1	How often did you miss taking one or more of your medication in the last 2 weeks?	**Almost never**	**Occasionally**	**Frequently**
2	Are you unsure/confused about what your medications are for?	**YES**	**NO**	**N/A**
3	Are you unsure/confused about how or when to take your medications?	**YES**	**NO**	**N/A**
4	Are you unsure/confused about why you need to take your medications?	**YES**	**NO**	**N/A**
5	Do you have any medications your cannot afford?	**YES**	**NO**	**N/A**
6	Do you have trouble getting your medications due to the inability get to the pharmacy or the inability to have them delivered?	**YES**	**NO**	**N/A**
7	Do you have concerns/questions about your medication's side effects?	**YES**	**NO**	**N/A**
8	Do you have difficulty taking medicine the way you are instructed?	**YES**	**NO**	**N/A**

ISSUES EFFECTING YOUR HEALTH

1	In the past year, was there a time when you couldn't afford to see a doctor?	**YES**	**NO**		
2	Are you worried at times you cannot get your medicine due to expenses?	**YES**	**NO**		
3	Do you ever eat less because there isn't enough food?	**YES**	**NO**		
4	Are you worried that in the next few months you may not have housing?	**YES**	**NO**		
5	Do you feel your safety is threatened in your home?	**YES**	**NO**		
6	In the past year, have you had a hard time paying your utility bills?	**YES**	**NO**		
7	Do you feel like it is a hardship to obtain household supplies?	**YES**	**NO**		
8	Do you have any problems with access to transportation to get to your medical appointments?	**YES**	**NO**		
9	Do you need a translator to communicate with your provider?	**YES**	**NO**		
10	Do you have difficulty learning about your medical condition from the information given to you or what is told to you?	**YES**	**NO**		
11	Do you miss having people around you?	**YES**	**NO**		
12	Do you receive enough support from family and friends?	**ALWAYS**	**USUALLY**	**SOMETIMES**	**NEVER**
13	How confident are you that you can control and manage most of your health problems?	**VERY**	**SOMEWHAT**	**NOT VERY**	**N/A**

SATISFACTION WITH ACCESS

1	In the past 12 months, how often did you get an appointment in the amount of time you felt was appropriate?	**ALWAYS**	**USUALLY**	**SOMETIMES**	**NEVER**
2	In the past 12 months, how satisfied are you with the care or treatment you received in this office?	**VERY**	**SOMEWHAT**	**NOT VERY**	**N/A**

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HOME SAFETY

- In all living areas, avoid throw rugs and secure any loose carpet edges with nonskid tape.
- Make sure the floor is devoid of clutter and nightlights or motion-sensitive lighting are maintained throughout the home.
- Adding contrasting color strips to stairs aids in weakened depth perception and implementing grab bars and handrails helps with depreciated balance.
- Emergency numbers should be listed in large print by each phone. It's also smart to consider installing an electronic emergency response system, like Life Alert®

MEDICATION SAFETY

- Know the names of your medicines.
- Complete a Medication List and keep the list updated. Take it with you on each visit to your doctor or pharmacist, and whenever you travel away from home.
- Take your medicines until they're gone. This is especially important for antibiotics. If you are prescribed two weeks' worth of pills, don't stop them in a few days "because you're feeling better." These medicines need to be taken for the total duration of time that they are prescribed to completely clear the infection and keep it from coming back.
- Don't mix pills in bottles with other pills. Keep them in their original container (unless you place them in a dispenser).
- Be alert for any side effects, especially when starting a new medicine or increasing the dose of an existing medicine. Any new symptom in an older adult should be considered a medicine side effect until proved otherwise. Check with your doctor or pharmacist if you have any questions or suspect that your medicine may be causing problems.
- Use one pharmacy for all your prescription medicines. This will reduce the chance that you will obtain conflicting medicines from different pharmacies.
- Ask your pharmacist's advice before splitting or crushing any pills. Some pills should only be swallowed whole and may produce dangerous effects if the pill is altered.
- Keep all medicines out of the reach of children.
- Discard any medicines that you are no longer taking. Having old medicines around the house increases the risk that you or a family member might take them by accident, or that a child might get into them. Keep your medicines securely stored in a safe place.

nsim 9th STREET INTERNAL MEDICINE

Patient's Name _____

Medicare Preventative Services Recommendations for You

- ☐ Mammogram every 1- 2 years for women until age 85
- ☐ Glaucoma screening with your optometrist or ophthalmologist every 2 years
- ☐ Vision screening as recommended by your eye care provider
- ☐ Diabetes screening every year
- ☐ Cholesterol screening at least every 5 years
- ☐ Colonoscopy screening every 10 years until age 75 or more frequently as recommended
- ☐ Influenza vaccine yearly
- ☐ Shingles vaccine once after age 60 (This may or may not be covered by Medicare part D depending upon insurance coverage purchased by patient)
- ☐ Pneumonia vaccine (Pneumoccal-23) once after age 65 (This is covered by Medicare)
- ☐ Other Pneumonia vaccine (Prevnar-13) once after age 65 (This is covered by Medicare)
- ☐ Tetanus /pertussis/diphtheria booster once after age 65 and every 10 years (This is NOT paid for by Medicare and is an additional cost to the patient)
- ☐ DEXA scan screening for osteoporosis in women after age 65 and in high risk men after age 70
- ☐ Stop smoking
- ☐ Decrease alcohol
- ☐ Exercise for 30 minutes or more 3 times a week
- ☐ Lose weight
- ☐ Dietary Recommendations:
  - Make one half your plate fruits and vegetables
  - Make at least half your grains whole
  - Choose foods and drinks with little or no added sugars
  - Look out for salt (sodium) in foods you buy
  - Eat fewer foods that are high in saturated fats (animal fat, butter, cream, whole milk, stick margarine, coconut and palm oil
  - Eat the right amount of calories for you (get your personal daily calorie limit at www.ChooseMyPlate.gov)
  - Use food labels to help you make better food choices