CLEVELAND MEDICAL ASSOCIATES, PLLC.

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Today's Date: _____

WELLNESS VISIT FORM

PATIENT NAME: _____ DATE OF BIRTH: _____

GENDER (Circle One): **FEMALE** **MALE** EMPLOYMENT STATUS: **EMPLOYED** **RETIRED** **DISABLED**

AGE GROUP: **65-69** **70-79** **80+** NUMBER OF CHILDREN: _____

MARITAL STATUS: **MARRIED** **SINGLE** **DIVORCED** **WIDOWED** **OTHER**: _____

RACE: **WHITE** **BLACK/AFRICAN AMERICAN** **NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER**
AMERICAN INDIAN/ALASKAN NATIVE **HISPANIC OR LATINO ORIGIN OR DESCENT** **ASIAN** **OTHER**

FALL(S) ASSESSMENT

HAVE YOU FALLEN IN THE PAST YEAR? **YES** **NO**

DO YOU WORRY ABOUT FALLING? **YES** **NO**

DO YOU FEEL UNSTEADY STANDING OR WALKING? **YES** **NO**

DO YOU USE A CANE OR WALKER? **YES** **NO**

HAVE YOU SEEN A PHYSICAL THERAPIST IN THE PAST YEAR? **YES** **NO**

IF **YES**, WHEN, WHERE, AND WHY?

_____

_____

BLADDER CONTROL ASSESSMENT

IS BLADDER CONTROL A PROBLEM FOR YOU? **YES** **NO**

IN THE PAST 60 DAYS, HAS URINE LEAKAGE CHANGED YOUR DAILY ACTIVITIES? **YES** **NO**

IN THE PAST 60 DAYS, HAS URINE LEAKAGE INTERFERED WITH YOUR SLEEP? **YES** **NO**

IF URINE LEAKAGE IS A PROBLEM FOR YOU, WOULD YOU BE WILL TO TRY ONE OF THE FOLLOWING:

MEDICATIONS: **YES** **NO**

EXERCISE: **YES** **NO**

SURGERY: **YES** **NO**

PHYSICAL HEALTH

HOW OFTEN DOES PHYSICAL HEALTH INTERFERE WITH YOUR DAILY ACTIVITIES?

ALMOST NEVER **OCCASIONALLY** **FREQUENTLY**

APPROXIMATELY HOW MANY DAYS EACH WEEK ARE YOU PHYSICALLY ACTIVE?

0-1 DAYS **2-3 DAYS** **4 OR MORE DAYS**

ARE YOU AS ACTIVE AS OTHER PEOPLE YOUR AGE? **YES** **NO**

HOW OFTEN DO YOU CHOOSE TO TAKE THE STAIRS OVER AN ELEVATOR OR ESCALATOR?

ALMOST NEVER **OCCASIONALLY** **FREQUENTLY**

DURING THE PAST 4 WEEKS, HOW MUCH BODILY PAIN HAVE YOU GENERALLY HAD?

NO PAIN **VERY MILD PAIN** **MILD PAIN** **MODERATE PAIN** **SEVERE PAIN**

WHAT IS YOUR PAIN LEVEL TODAY ON A SCALE FROM 1-10?

0 1 2 3 4 5 6 7 8 9 10

DURING THE PAST 4 WEEKS, WHAT WAS THE HARDEST PHYSICAL ACTIVITY YOU COULD DO FOR AT LEAST 2 MINUTES?

VERY HEAVY **HEAVY** **MODERATE** **LIGHT** **VERY LIGHT**

CAN YOU GET TO PLACES OUT OF WALKING DISTANCE WITHOUT HELP? (i.e. CAN YOU TRAVEL ALONE BY BUS, TAXI, OR DRIVE YOUR OWN CAR)? **YES** **NO**

CAN YOU SHOP FOR GROCERIES OR CLOTHES WITHOUT HELP? **YES** **NO**

CAN YOU PREPARE YOUR OWN MEALS? **YES** **NO**

CAN YOU DO YOUR OWN HOUSEWORK WITHOUT HELP? **YES** **NO**

CAN YOU HANDLE YOUR OWN MONEY WITHOUT HELP? **YES** **NO**

DO YOU NEED HELP WITH ANY OF THE FOLLOWING:

EATING? **YES** **NO**

BATHING? **YES** **NO**

DRESSING? **YES** **NO**

GETTING AROUNG YOUR HOME? **YES** **NO**

ARE YOU HAVING DIFFICULTIES DRIVING YOUR CAR?

OFTEN **SOMETIMES** **NEVER** **NOT APPLICABLE/I DO NOT USE A CAR**

DO YOU FASTEN YOUR SEAT BELT WHEN YOU ARE IN A CAR?

ALWAYS **SOMETIMES** **NEVER**

PHYSICAL HEALTH (CONTINUED)

HOW OFTEN DURING THE PAST 4 WEEKS HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?

FALL OR DIZZY WHEN STANDING UP	**NEVER**	**SELDOM**	**SOMETIMES**	**OFTEN**
SEXUAL PROBLEMS	**NEVER**	**SELDOM**	**SOMETIMES**	**OFTEN**
TROUBLE EATING	**NEVER**	**SELDOM**	**SOMETIMES**	**OFTEN**
TEETH OR DENTURES	**NEVER**	**SELDOM**	**SOMETIMES**	**OFTEN**
USING THE PHONE	**NEVER**	**SELDOM**	**SOMETIMES**	**OFTEN**

ARE YOU A SMOKER? **YES** **NO**

ARE YOU WILLING TO QUIT? **YES** **NO**

DURING THE PAST 4 WEEKS, HOW MANY DRINKS OR WINE, BEER, OR OTHER ALCOHOLIC BEVERAGES HAVE YOU HAD?

10 OR MORE PER WEEK **6-9 PER WEEK** **2-5 PER WEEK** **1 OR LESS PER WEEK** **NOT AT ALL**

HAVE YOU BEEN GIVEN ANY INFORMATION ABOUT THE FOLLOWING:

HAZARDS IN YOUR HOUSE THAT MIGHT HURT YOU? **YES** **NO**

KEEPING TRACK OF YOUR MEDICATION? **YES** **NO**

EMOTIONAL HEALTH

HOW WOULD YOU DESCRIBE YOUR EMOTIONAL HEALTH? **CALM** **ENERGETIC** **DOWNHEARTED**

IN THE LAST MONTH, HAS YOUR EMOTIONAL HEALTH (FEELING ANXIOUS OR DEPRESSED) INTERFERED WITH YOUR DAILY ACTIVITIES? **YES** **NO**

HOW MANY HOURS OF SLEEP DO YOU TYPICALLY GET EACH NIGHT?

5 OR LESS HOURS **6-7 HOURS** **8 OR MORE HOURS**

IN THE LAST MONTH, HAVE YOU ACCOMPLISHED LESS THAN YOU WOULD LIKE OR BEEN MORE CARELESS AT WORK OR WHILE PERFORMING DAILY ACTIVITIES? **YES** **NO**

ARE YOU WORRIED ABOUT YOUR MEMORY? **YES** **NO**

COLORECTAL SCREENING

HAVE YOU HAD A COLORECTAL SCREENING IN THE PAST 10 YEARS? **YES** **NO** IF **YES**, WHEN? _____

FEMALE SCREENING

HAVE YOU HAD A MAMMOGRAM IN THE LAST 2 YEARS? **YES** **NO** IF **YES**, WHEN? _____

LOCATION OF MAMMOGRAM: _____

HAVE YOU HAD A PAP SMEAR? **YES** **NO** IF **YES**, WHEN? _____

LOCATION AND PROVIDER OF PAP SMEAR: _____

GENERAL SCREENING

HAVE YOU HAD AN ABNORMAL AORTIC ANEURYSM ULTRASOUND? **YES** **NO** IF **YES**, WHEN? _____

HAVE YOU HAD AN EYE EXAM IN THE LAST 2 YEARS? **YES** **NO** IF **YES**, WHEN & WHERE? _____

ARE THERE ANY PREVENTATIVE TESTS YOU HAVE DONE RECENTLY (i.e. MAMMOGRAMS/LABS/X-RAYS)? **YES** **NO**

IF **YES**, WHAT TESTS & WHERE? _____

DIRECTIVE FOR HEALTH CARE

DO YOU HAVE A LIVING WILL OR ADVANCED DIRECTIVE? **YES** **NO** IF **YES**, PLEASE PROVIDE US WITH A COPY

IMMUNIZATIONS

HAVE YOU HAD ANY RECENT IMMUNIZATIONS? **YES** **NO**

IF **YES**, PLEASE CIRCLE WHICH APPLY:

PNEUMONIA VACCINE **FLU VACCINE** **COVID**

SHINGLES VACCINE **TDAP** **HEPATITIS B VACCINE**

MEDICATIONS

REMEMBERING TO TAKE YOUR MEDICATION CAN SOMETIMES BE CHALLENGING. IN THE LAST 2 WEEKS, HAVE YOU FORGOTTEN TO TAKE YOUR MEDICATIONS? **YES** **NO**

UNDERSTANDING HOW AND WHEN TO TAKE MEDICATION AND KNOWING WHY IT WAS PRECRIBED IS IMPORTANT. DO YOU HAVE ANY QUESTIONS ON HOW AND WHEN TO TAKE YOUR MEDCATION OR WHY IT WAS PRECRIBED? **YES** **NO**

SOME MEDICATIONS ARE DIFFICULT TO AFFORD, EVEN WITH HELP FROM INSURANCE. DO YOU HAVE ANY MEDICATIONS THAT ARE UNAFFORDABLE? **YES** **NO**

EVERY MEDICATION HAS SIDE EFFECTS. DO YOU HAVE ANY UNANSWERED WORRIES OR QUESTIONS RELATED TO YOUR MEDCATIONS OR SIDE EFFECTS? **YES** **NO**

*************REVIEW YOUR MEDICATION LIST WITH YOUR PHYSICIAN*************

LIST ANY MEDICATIONS THAT YOU CURRENTLY TAKE (INCLUDING OVER THE COUNTER)		
NAME	STRENGTH	DIRECTION

LIST ANY PROVIDERS AND THEIR SPECIALTIES	
PROVIDER NAME	SPECIALTIES