# IMC Annual Wellness Exam

Last Name: ____________________________________________________________________

First Name: ___________________________________________________________________

Date of Birth: _____________________________ Today's Date: ________________________

For each question, select the answer that best describes you.

## General Health: How would you rate your general health?

1. **Overall Health**

   Excellent    Very Good    Good    Fair    Poor

2. **Physical Health** (Compared to last year)

   Much Better    Slightly Better    Same    Slightly Worse    Much Worse

3. **Eyesight**

   Better    Same    Slightly Worse    Much Worse

4. **Hearing**

   Better    Same    Slightly Worse    Much Worse

5. **Emotional Health**

   Much Better    Slightly Better    Same    Slightly Worse    Much Worse

6. **Pain** (Within the past 7 days, how much pain have you experienced?)

   None    Some    A Lot

   If you answered "Some" or "A Lot", please rate the severity of your pain on a scale of 1 to 10. (1 being the least severe pain and 10 being the most severe pain; circle one)

   **1    2    3    4    5    6    7    8    9    10**

7. **Weight** (In the past 6 months, have you lost or gained 10 pounds without intentionally trying?)

   Yes    No

   If you answered "Yes", was the weight:  Lost    or    Gained

Name: ____________________________________________ DOB: _____________ Date: __________

## Emotional Health: (During the past month)

1. Have you felt down, depressed or hopeless? Yes No
2. Have you often had little interest or pleasure in doing things? Yes No
3. Have you felt anxious, nervous or on edge? Yes No

## Falls and Injuries:

1. Have you broken any bones within the past 12 months? Yes No
2. Have you had a bone mineral density test within the past 24 months? Yes No
3. Have you fallen within the past 12 months? Yes No
   a. If Yes, how many times? __________________

## Bladder and Bowel Health:

1. Within the past 6 months, have you accidentally leaked urine? Yes No
   a. If Yes, did you leak urine due to:

   Coughing/Sneezing/Laughing Holding to long No reason

2. Have you experienced bowel incontinence or loss of bowel control? Yes No

## Immunizations:

1. Have you had an Influenza/Flu vaccination within the past year? Yes No
2. Have you had a pneumonia vaccination after the age of 65? Yes No

   Prevnar 13 Pneumovax 23

3. Have you had a Shingles vaccination after the age of 65? Yes No

   Zostavax Shingrix

4. When was your last Tetanus/Diphtheria vaccination? Date: _________________

Name: _____________________________________________ DOB: ______________ Date: __________

## Preventative Health: Have you had any of the following screenings?

1. Breast Exam (Mammogram)     Yes     No     Date: _____________

   Normal Exam     Abnormal Finding

   **Physician Use Only:     Up to Date     Scheduled     Declined**

2. Prostate Exam     Yes     No     Date: _____________

   Normal Exam     Abnormal Finding

   **Physician Use Only:     Up to Date     Scheduled     Declined**

3. Colon Cancer     Yes     No     Date: _____________

   Colonoscopy     Cologuard

   **Physician Use Only:     Up to Date     Scheduled     Declined**

   a. The U.S. Preventive Services Task Force recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.
   b. The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history.
      i. Adults in this age group who have never been screened for colorectal cancer are more likely to benefit.
      ii. Screening would be most appropriate among adults who:
         1. Are healthy enough to undergo treatment if colorectal cancer is detected.
         2. Do not have comorbid conditions that would significantly limit their life expectancy.

4. Cholesterol (Routine lab work)     Yes     No     Date: _____________

5. Glaucoma Eye Exam     Yes     No     Date: _____________

   **Physician Use Only:     Up to Date     Scheduled     Declined**

6. Diabetes (Routine lab work)     Yes     No     Date: _____________

   a. The U.S. Preventive Services Task Force recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese.

Name: ____________________________________________ DOB: _____________ Date: __________

7. Hepatitis C Yes No Date: _____________
   a. The U.S. Preventive Services Task Force recommends offering a one-time screening for HCV infection to adults born between 1945 and 1965.

   **Physician Use Only: Up to Date Scheduled Declined**

8. Sleep study for Sleep Apnea Yes No Date: _____________

   **Physician Use Only: Up to Date Scheduled Declined**

   | | | | |
   |---|---|---|---|
   | a. | Do you snore? | Yes | No |
   | b. | Are you tired or experience daytime fatigue? | Yes | No |
   | c. | Observed to have stop breathing during sleep? | Yes | No |
   | d. | Do you have High Blood Pressure? | Yes | No |
   | e. | Are you overweight? (BMI greater than 28) | Yes | No |
   | f. | Is your neck circumference greater than 16 inches? | Yes | No |
   | g. | Are you male? | Yes | No |
   | h. | Over the age of 50 | Yes | --- |

   According to the “STOP-BANG” screening guidelines, a score of:

   1. 0-2 shows low risk of sleep apnea, no screening recommended
   2. 3-4 shows moderate risk of sleep apnea and encourages screening
   3. 5-8 shows high risk of sleep apnea and should be screened

9. Abdominal Aortic Aneurysm Yes No Date: _____________

   **Physician Use Only: Up to Date Scheduled Declined**

   a. The U.S. Preventive Services Task Force recommends a one-time screening for AAA with an ultrasound in men ages 65 to 75 years who have ever smoked.
   b. The U.S. Preventive Services Task Force recommends that clinicians selectively offer screening for AAA in men ages 65 to 75 years who have never smoked rather than routinely screening all men in this group.
   c. The U.S. Preventive Services Task Force concludes that the current evidence is insufficient to recommend screening for AAA in women ages 65 to 75 years who have ever smoked.
   d. The U.S. Preventive Services Task Force recommends against routine screening for AAA in women who have never smoked.

Name: ____________________________________________ DOB: ______________ Date: __________

10. Lung Cancer (Tobacco Use) Yes No Date: _____________

**Physician Use Only:** **Up to Date** **Scheduled** **Declined**

a. The U.S. Preventive Services Task Force recommends yearly lung cancer screening with low-dose CT scan of the chest for people who:

| | | | |
|---|---|---|---|
| i. | Have a history of heavy smoking, ***and*** | Yes | No |
| ii. | Smoke now or have quit within the past 15 years, ***and*** | Yes | No |
| iii. | Are between 55 and 80 years old | Yes | No |

*Heavy smoking* means a smoking history of 30 pack years or more. A *pack year* is smoking an average of one pack of cigarettes per day for one year. For example, a person could have a 30 pack-year history by smoking one pack a day for 30 years or two packs a day for 15 years.

Lung cancer screening is only recommended for adults who have no symptoms but who are at high risk for developing the disease because of their smoking history and age.

The Task Force recommends that yearly lung cancer screening stop when:

1. The patient turns 81 years old, or
2. The patient has not smoked in 15 years, or
3. The patient develops a health problem that makes him or her unwilling or unable to have surgery if lung cancer is detected

## Home Safety:

| | | | |
|---|---|---|---|
| 1. | Do you have trouble with the stairs within or outside your home? | Yes | No |
| 2. | Are there hazards within your home such as loose rugs or poor lighting? | Yes | No |
| 3. | Does your bathroom have grip bars within the bathtub or shower? | Yes | No |
| 4. | Does your home having working smoke alarms? | Yes | No |
| 5. | Does your home have working carbon monoxide detectors? | Yes | No |

Name: ____________________________________________ DOB: _____________ Date: __________

## Nutrition: Within the past 7 days

1. How many servings of fruits and vegetables do you typically eat per day?
   _________ servings per day

2. How many servings of high fiber foods or whole grains do you typically eat per day?
   _________ servings per day

3. How many servings of fried or high fat foods do you typically eat per day?
   _________ servings per day

4. How many sugar sweetened beverages do you typically drink per day?
   _________ servings per day

## Lifestyle Choices:

1. Do you currently smoke or use other forms of tobacco products? Yes No

   Type of tobacco product: ____________________________________________

2. Have you ever smoked or used other tobacco products in the past? Yes No

   Type of tobacco product: ____________________________________________

   If yes, when did you quit? ____________________________________________

3. Do you drink alcohol? Yes No

4. Do you drive? Yes No

5. Do you wear your seat belt? Yes No

6. How would you describe your current level of exercise or physical activity?

   ________________________________________________________________________

   ________________________________________________________________________

Name: _____________________________________________ DOB: ______________ Date: __________

## Activities and Daily Living: Can you

1. Get out of bed by yourself? Yes No
2. Bathe yourself? Yes No
3. Dress yourself? Yes No
4. Make your own meals? Yes No
5. Do your own laundry/housekeeping? Yes No
6. Do your own shopping Yes No
7. Manage your money, pay your bills and keep track of your expenses? Yes No
8. Take you medications as directed by your physician? Yes No

Name: _____________________________________________ DOB: ______________ Date: __________

## List of Your Doctors:

Please list any doctors that you have seen over the past year and the medical problems that were/are being treated, if needed continue listing on the back of this page

| Doctor's Name: | Specialty: | Medical Condition: |
|---|---|---|
| 1. ___________________________________ | ________________ | ___________________________ |
| 2. ___________________________________ | ________________ | ___________________________ |
| 3. ___________________________________ | ________________ | ___________________________ |
| 4. ___________________________________ | ________________ | ___________________________ |
| 5. ___________________________________ | ________________ | ___________________________ |
| 6. ___________________________________ | ________________ | ___________________________ |
| 7. ___________________________________ | ________________ | ___________________________ |

## Hospitalizations and Emergency Room Visits in the Past Year:

| Date of Admission or Visit: | Reason for Admission or Visit: |
|---|---|
| 1. ________________________________________ | ________________________________________ |
| 2. ________________________________________ | ________________________________________ |
| 3. ________________________________________ | ________________________________________ |
| 4. ________________________________________ | ________________________________________ |

Name: ____________________________________________ DOB: _____________ Date: __________

## Advance Directives:

1. Have you decided who would speak for you and make health care treatment choices for you if you became ill and could not make them for yourself?

   Yes No

2. If you answered "yes" to the above question, have you spoken to that person about your wishes and medical decisions?

   Yes No

3. Have you completed a written advance directive; that is, a living will and/or health care power of attorney?

   Yes No

## Social Support:

Do you have someone who will help you manage your health care, such as a friend or family member?

Yes No

If yes, please provide their contact information.

Name: ______________________________________________________________________

Relationship to the patient: _______________________________________________________

Street Address: _______________________________________________________________

City: ______________________________ State: ___________ Zip Code: ________________

Telephone number: (________) __________ - ________________

Are they on your HIPPA? Yes No

Name: ____________________________________________ DOB: ______________ Date: __________

**Patient Health Questionnaire (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems. Circle the number that best answers the questions.

| Problems: | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself – or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed; or being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

**Total Score: ______________________**

| If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all ______________<br>Somewhat difficult ______________<br>Very difficult ______________<br>Extremely difficult ______________ |
|---|---|

Name: ___________________________________________ DOB: _____________ Date: __________

# PHQ-9 Patient Depression Questionnaire

**For initial diagnosis:**

1. Patient completes the PHQ-9 Quick Depression Assessment
2. If there are at least 4 positive answers, then consider a depressive disorder. Add up the score to determine the severity.

**Consider Major Depressive Disorder**

- If there are at least 5 positive answers

**Consider Other Depressive Disorder**

- If there are 2-4 positive answers

**Note:** Since the questionnaire relies on patient self-reporting, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning and ruling out normal bereavement, a history of a Manic Episode (Bipolar), and a physical disorder, medication, or other drugs as the biological cause of the depressive symptoms.

**To monitor severity over time for newly diagnosed patients or patient in current treatment for depression:**

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment
2. Take note to the number of positive answers
3. Add up the total score
4. Refer to the accompanying PHQ-9 scoring box to interpret the total score
5. Results may be included in the patients file to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention

**Interpretation of the total score:**

| Total Score | Depression Severity |
|---|---|
| 1-4 | Minimal depression |
| 5-9 | Mild depression |
| 10-14 | Moderate depression |
| 15-19 | Moderately severe depression |
| 20-27 | Severe depression |

PHQ-9 Copyright Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD is a registered trademark of Pfizer Inc.

Name: ______________________________________________ DOB: __________ Date: __________

# THANK YOU!

You have completed your health questionnaire. Please bring it with you and give it to your medical provider.

Once again, thank you for filling out the form. You should feel good about being proactive. Following through with preventive care is one of the best things you can do for your well-being.

Your health is important, and your health care providers are here to help protect it with the resources, information and personal support you need.

Reminder: Bring either all of your medications with you to your Wellness Exam **or** an updated list of your current medications. In addition, please include all over the counter medications and supplements.

## For Office Use Only:

Physician Signature: ____________________________________________

Date: ________________________________________________________