ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name:____ **DOB:**_________________________________

PLEASE INDICATE THE NAMES OF ANY SPECIALISTS YOU ARE CURRENTLY SEEING:

(i.e., Cardiologists, Gastroenterologists, Gynecologists, Pulmonologists, Nephrologists, Neurologists, etc.)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

PLEASE LIST ALL OF YOUR MEDICATIONS:

Please list all medications that you are currently taking: Include all prescription medication, over the counter medication, and any vitamins/herbal remedies.

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.
13.	14.
15.	16.

SOCIAL HISTORY:

I currently Smoke	Yes / No	Frequency:________________
I currently consume Alcohol	Yes / No	Frequency:________________
I currently use THC	Yes / No	Frequency:________________
I currently use Opioids	Yes / No	Frequency:________________

FAMILY HISTORY:

List any changes in your family history: (☐No Change)

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Name:____ **DOB:**________________________________

FUNCTIONAL ABILITY (ADL):

Do you handle your own medication? Yes / No

Do you handle your own finances? Yes / No

Do you have an unsteady gait or difficulty walking? Yes / No

Are you having trouble performing tasks you've done all your life, like cooking or balancing the checkbook? Yes / No

ADVANCED DIRECTIVES:

Please check if you have the following:

___ Advanced Directives ___ Durable Power of Attorney ___Living Will ___DNR

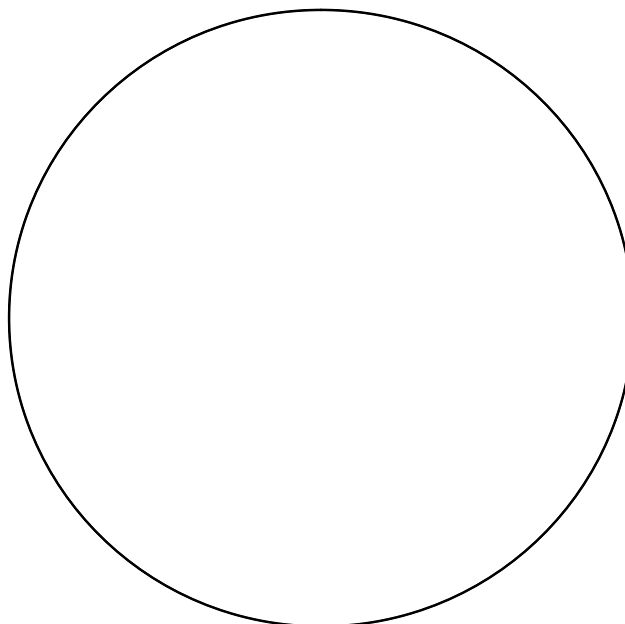
COGNITIVE SCREENING: (PROBLEM WITH MEMORY)

I noticed a decrease in my memory Yes / No

It is difficult for me to remember the names of common objects, like keys or coins Yes / No

CLOCK DRAWING TEST:

Draw numbers in the circle to make the circle look like the face of a clock and draw the hands of the clock to read "10 after 11 or 11:10."



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Name:____ **DOB:**________________________________

PREVENTATIVE TESTS:

Please list if you have had any of the following preventative tests:

General	Women Only
__ Colonoscopy Date:______________________ __ Bone Density Date:______________________ __ Flu Vaccine in the last Year Date:______________________ __ Pneumonia Vaccine in the last Year Date:______________________ __ Tetanus Vaccine in the last Year Date:______________________ __ Shingles Vaccine in the last Year Date:______________________ __ Covid-19 Vaccine in the last Year Date:______________________ **History Heart Disease** __ EKG Date:________________________ __ Echocardiogram Date:________________________ __ Cholesterol Screening Date:________________________	__Mammogram Date:__________________________ __Pap Smear Date:__________________________ **Men Only** __PSA Date:__________________________ **Diabetic Patients** __Hgb A1c Date:__________________________ __LDL Date:__________________________ __Eye Exam Date:__________________________

PATIENT HISTORY:

****This section is to be completed by the Provider ONLY**** ***Not to be completed by the patient.***

___ Reviewed Medical & Surgical History

Provider Initials: ______

ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name:______________________________________ **DOB:**______________________________

FALL SCREENING:

Desmond Fall Risk Questionnaire

Yes / No	Have you had a fall or near fall in the past year?
Yes / No	Do you have a fear of falling that restricts your activity?
Yes / No	Do you experience dizziness or a sensation of spinning when you lie down, tilt your head back, or roll over in bed?
Yes / No	Do you feel uneasy or unsteady when walking down the aisle of a supermarket, or in an area congested with other people?
Yes / No	Do you have difficulty walking in the dark, or on uneven surfaces such as gravel or a sloped sidewalk?
Yes / No	Do your feet or toes frequently feel unusually hot or cold, numb or tingly?
Yes / No	Do you wear bifocal glasses, or is your vision notably better in one eye?
Yes / No	Do you experience loss of balance, or a lightheaded/faint feeling when you stand up?
Yes / No	Do you take medication for depression, anxiety, nerves, sleep or pain?
Yes / No	Do you take four or more prescription medications daily?
Yes / No	Do you feel like your feet just won't go where you want them to go?
Yes / No	Do you feel like you can't walk in a straight line, or are pulled to the side walking?
Yes / No	Has it been longer than six months since you participated in a regular exercise program?
Yes / No	Do you feel that no one really understands how much dizziness and balance problems affect your quality of like?
Yes / No	Are you interested in improving your balance and mobility?