Sumeet K. Anand M.D, P.C

Patient Name:_____

Date: _____

ANNUAL WELLNESS VISIT

Physical exams are required for each patient. Following is a list of questions which you will be required to answer to better understand your health and meet your needs.

When Was your Last Physical Exam?

Please List all or update your current Specialist you are seeing:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list or update your past surgical/Hospitalizations in the last year:

_____
_____
_____

List all Medications you are currently taking or edit the list provided of current medications with us:

_____
_____
_____

Do you have any medication or environmental allergies? ☐ **Yes** ☐ **No**

List:_____ _____

When was the last time you had blood work done? _____

Do you currently See a Dermatologist regularly? ☐ **Yes** ☐ **No**

Tobacco Screening and Cessation (Patients 18 and Over)

☐ **Non Smoker** ☐ **Former Smoker** ☐ **Current Smoker**

When did you start smoking? _____ **When did you start?** _____

When did you Quit smoking? _____

Alcohol Screening and Cessation

☐ Non Drinker ☐ Former Drinker ☐ Current Drinker

Please circle Yes or No

1. Have you ever felt you should cut down on your drinking? Yes No
2. Have people annoyed you by criticizing your drinking? Yes No
3. Have you ever felt bad or guilty about your drinking? Yes No
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hang over? Yes No

Mental Health Screening:

Do you have any other health/mental concerns you would like to address including:

- Depression
- Anxiety
- Memory loss
- Any other concerns: _____

Depression Screening (PHQ2): Over the past 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	several days	more than ½ the day's	nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed or hopeless	0	1	2	3

( ) Pass ( ) Fail

Pain Screening:

Are you currently in pain?

( ) None ( ) Very Mild ( ) Mild ( ) Moderate ( ) Severe

What is your Level of Physical Activity? ( ) Very Heavy ( ) Heavy ( ) Moderate ( ) Light

Are you able to perform these activities independently?

- Dressing ( ) Yes ( ) No
- Bathing ( ) Yes ( ) No
- Walking ( ) Yes ( ) No
- Shopping ( ) Yes ( ) No
- Housekeeping ( ) Yes ( ) No
- Managing medications ( ) Yes ( ) No
- Handling Finances ( ) Yes ( ) No

Fall Risk Screening (patients 65 and over)

Have you had two or more falls in the past year? ☐ Yes ☐ No

Do you have any balancing problems? ☐ Yes ☐ No

Cognitive screening:

- Direct Observation of Cognitive Behavior: ☐ Intact ☐ Impaired
- Information Obtained from Family, Friends, & Caretakers ☐ Yes ☐ no

Cancer Screening: (please provide Date and year)

Cervical Cancer Screen/PAP Smear (Women 21-65 y/o yearly): _____

Breast Cancer screening/ Mammogram (Woman 40-74y/o biennial):_____

☐ Colonoscopy If so when _____ ☐ Stool DNA test If so when _____

PSA (Men 50 and older): _____

Genetic Screening:

Do you have a personal or family history of cancer? _____

If answered no, skip to immunizations.

If answered yes please read below.

- If you are below 70 years old and meet the criteria for hereditary cancer testing we now offer genetic testing in our office.
- Please ask our staff for the questionnaire if you are interested.

Immunizations: (Please provide date and year)

Influenza (yearly)_____

Tetanus Td (every 10years)_____

Gardasil-9 (18-26yr) Series 1:____Series 2: ____Series 3: ____ (27-45 yr shared decision making)_____

Shingles (Shingrix) (50yrs or older): Series 1:_____

(2-6 months later) Series 2:_____

Pneumococcal (>65y/o)

1. PPSV23_____
2. PCV 13 _____

For Diabetic's only: (please provide date and year)

Last HBA1C_____ Last Urine Analysis/ Microalbumin: _____

Last Foot exam: _____ Last Eye exam_____

- American Diabetes Association recommends all diabetics to see an Ophthalmologist and Podiatrist annually

Please Initial _____

Cardiac Workup (if applicable)

Last ECG _____

Echocardiogram_____

Stress test_____

Holter monitor_____

Carotid Doppler_____

Other (provide dates and year)

Osteoporosis/DEXA scan_____

Visual acuity screen_____

Hearing screen_____

Hepatitis C Antibody _____

Counselling:

Smoking_____

Alcohol_____

Substance abuse_____

Are you prescribed for any annual or periodic diagnostic testing? ☐ Yes ☐ No

If yes, Please describe _____

Signature: _____