Your Annual **Wellness Visit** Questionnaire

Comprehensive Care Center of Irvine
Patient Centered Healthcare

Member Name: _____
Date of Birth: _____
PCP's Name: _____

Date of Annual Wellness Visit: _____

Bring this completed form to review with your doctor at your **Annual Wellness Visit**. Some items may not apply to you. A physical exam is **NOT** included in this visit. *Do not use this visit for a physical or routine office visit.*

Patient Section: (please fill out before your visit)

Family History

_____

_____

Physical health: Any change from last year? Y/ N
Past Medical History/ Past Surgical History

_____

_____

_____

_____

Current Medicines/Vitamins/Supplements **CPT II 1159F AND 1160F*

_____

_____

_____

_____

Do you need help managing your medicines? Y / N

Allergies _____

_____

Please list any other Doctors caring for you:
(Name/Specialty/Reason)

_____

_____

_____

Please list medical supplies/equipment & vendors

_____

_____

Do you have an **Advanced Directive**? Y / N
**CPT II – 1158F*

Do you have a Durable Power of Attorney? Y/ N
(Name/Number) _____

How do you rate your **health** in general?
Poor Fair Good Very good Excellent

Do you walk/**exercise** 3 or more times a week? Y / N

Urine: Any leakage? Y / N **CPT II – 1090F*

Do you have to strain to **hear**/understand conversations? Y / N

Balance: Any falls in the past 6 months? Y / N
Any trouble walking or standing? Y / N
**CPT II – 0518F*

Chronic Daily Pain: rate the level of your pain
(No Pain) 0 1 2 3 4 5 (Severe)
(*none *1126F)* *(*chronic or daily pain present CPT II - 1125F)*

Compared to a few years ago, do you have MORE trouble:
Remembering things that happened recently? Y / N
Recalling conversations after a couple of days? Y / N
Trouble paying bills/managing money? Y / N
**CPT II – 3755F*

Social & emotional: Do you have support from friends or family? Y / N

(Please circle all that apply) **CPT II – 1170F*
Do you need help **eating, bathing, dressing, toileting, shopping, and/or cooking**?

Habits: (*please check if you …)*
□ Smoke: (#) ___ /day for (#) ____ years *(*1000F)*
□ Drink Alcohol: (#) ____ per day / week / month

Does your Home have: *(check all that apply)*
Working detectors: □ Smoke □ Carbon Monoxide
□ Firearms (Guns)
□ Throw rugs □ Non-slip bath mat
□ Stairs □ Handrails

Safety: Do you drive? Y / N
Wear seatbelts in the car? Y / N

Nutrition: Did you lose or gain more than 5 lbs. in the last month? Y / N

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)				
Over the *last 2 weeks*, how often have you been bothered by any of the following 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
If you answered "Not at all" to both questions above, you may STOP HERE				
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 to 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 the opposite – 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 in some way	0	1	2	3
(office use only) Totals				
(office use only) 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? (please circle)			
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

CPT II: 3725F