Thank you for scheduling your Annual Wellness Visit. Attached are several documents that need to be completed before your appointment on [Insert AWV Appointment Date] in order to better work with you to establish your personalized prevention plan. Please complete all forms in this packet and bring them to your visit. You should plan on this visit requiring at least 30 minutes to complete, perhaps a bit longer if your provider is addressing additional specific medical concerns.

Things to bring to your Annual Wellness Visit:

- Your Health Risk Assessment (HRA) Form
- The names of all providers on your healthcare team, including any home health agency or specialists
- The names medical equipment supply companies (ex. oxygen supplier)
- The name of your medications, including over-the-counter drugs, vitamins and herbals
- The name and location of the pharmacies you use
- Please also bring a bag with all of your medications to your visit with you
- You may also bring a family member or caregiver with you

Thanks in advance for completing these documents. We look forward to partnering with you to make your good health our top priority.

Please complete the enclosed form prior to your visit and bring this with you to your Annual Wellness Visit appointment.

What to bring to your Annual Wellness Visit

Name:_____ Date of Birth:_____

The names of all the providers on your healthcare team including specialists (home health agency, eye doctor, cardiologists, foot doctor):

Name	Specialty

HEALTH RISK ASSESSMENT

- **Activities of Daily Living**

Are you able to care for yourself?
(Circle one) Yes No

Are you blind or do you have difficulty seeing?
(Circle one) Yes No

Are you deaf or do you have serious difficulty hearing?
(Circle one) Yes No

Do you have difficulty walking or climbing stairs?
(Circle one) Yes No

Do you have difficulty dressing or bathing?
(Circle one) Yes No

Do you have difficulty doing errands alone?
(Circle one) Yes No

Are you able to walk?
(Check one)

- Yes: walks without restrictions
- Yes: walks with assistive device
- Yes: limited self-mobility with assistive device(s); generally relies on wheeled mobility
- No: Confined to a chair
- No: Independent in wheelchair
- No: Requires minimal help in wheelchair
- No: Dependent on helper pushing wheelchair
- No: unable to walk
- No: Unable to initiate walking
- No Bed-ridden

Do you have transportation difficulties?
(Circle one) Yes No

- **Advanced Directive**

(Circle one) Yes No

Do you have a medical power of attorney?
(Circle one) Yes No

- **Substance Use**

Do you or have you ever smoked tobacco?
(Check one)

- Never smoker
- Former Smoker
- Current every day smoker
- Current some days smoker
- Smoker-current status unknown
- Unknown if ever smoked
- Decline to disclose (refuse)

How many years have you smoked tobacco? _____

At what age did you start smoking tobacco? _____

What is your current pack years?
(Check one)

- <=10 Pack Years
- 10-19 Packs Years
- 20-29 Pack Years
- 30+ Pack Years

How much tobacco do you smoke?
(Check one)

- None
- 1 pack per week
- 2 pack per week
- ¼ pack per day
- ½ pack per day
- 1 pack per day
- 2 packs per day
- 3 or more packs per day

When did you quit smoking?
(Check one)

- 1-5 years since last cigarette
- 6-10 years since last cigarette

- 11-15 years since last cigarette
- 16+ years since last cigarette

Do you or have you ever used any other forms of tobacco or nicotine?
(Circle one) Yes No

Do you or have you ever used e-cigarettes or vape?
(Circle one) Yes No

Do you or have you ever used smokeless tobacco?
(Circle one) Yes No

Has tobacco cessation counseling been provided?
(Circle one) Yes No

What is your level of alcohol consumption?
(Check one)

- None
- Occasional
- Moderate
- Heavy

Do you use any illicit or recreational drugs?
(Circle one) Yes No

What is your level of caffeine consumption?
(Check one)

- None
- Occasional
- Moderate
- Heavy

• Home and Environment

Have there been any changes to your family or social situation?
(Circle one) Yes No

Are you a caregiver?
(Circle one) Yes No

Where do you live?
(Check one)

- Single- level house

- Multi-level house
- Apartment
- Trailer
- Condo
- other

Do you have any pets?
(Circle one) Yes No

Do you have smoke and carbon monoxide detectors in your home?
(Circle one) Yes No

Are you passively exposed to smoke?
(Circle one) Yes No

Are there any smokers in your house?
(Circle one) Yes No

Are there any guns present in your home?
(Circle one) Yes No

- **Lifestyle**

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?
(Check one)

- Not at all
- Only a little
- To some extent
- Rather much
- Very much

Do you participate in social media?
(Circle one) Yes No

Do you use your seat belt or car seat routinely?
(Circle one) Yes No

- **Education and Occupation**

What is the highest grade or level of school you have completed or the highest degree you have received?

Are you currently employed?
(Circle one) Yes No

- **Marriage and Sexuality**

What is your relationship status?

Are you sexually active?
(Circle one) Yes No

How many children do you have?

- **Public Health and Travel**

Have you recently traveled abroad?
(Circle one) Yes No

- **Diet and Exercise**

What type of diet are you following?
(Check one)

- Regular
- Vegan
- Vegetarian
- Gluten free
- other

What is your exercise level?
(Check one)

- None
- Occasional
- Moderate
- Heavy

How often is stress a problem for you in handling such things as your health, finances, family or social relationships?
(Check one)

- Never
- Seldom
- Sometimes
- Often
- Always

Are you dissatisfied with your current level of social interaction with family and friends, and participation in activities outside your home?

(Circle one) Yes No

In the last 6 months, have you been in the emergency room or hospital?
(Circle one) Yes No

Do you have difficulty seeing or hearing?
(Circle one) Yes No

If yes, do you wear hearing aids?
(Circle one) Yes No

Do you have trouble taking your medications as prescribed?
(Circle one) Yes No

Do you or anyone you know have concerns about your driving abilities?
(Circle one) Yes No

Do you ever drive or ride in a vehicle without wearing your seatbelt?
(Circle one) Yes No

Are you worried or concerned that in the next two months you may not have a stable housing that you own, rent, or stay in as part of a household?

(Circle one) Yes No

MENTAL HEALTH SCREENING

Over the last two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling down, depressed, or hopeless

- Not at all

- Several days
- More than half the days
- Nearly every day

Trouble falling or staying asleep, or sleeping too much

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling tired or having little energy

- Not at all
- Several days
- More than half the days
- Nearly every day

Poor appetite or overeating

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling bad about yourself - or that you are a failure or have let yourself or your family down

- Not at all
- Several days
- More than half the days
- Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television

- Not at all
- Several days
- More than half the days

- Nearly every day

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

- Not at all
- Several days
- More than half the days
- Nearly every day

Thoughts that you would be better off dead or of hurting yourself in some way

- Not at all
- Several days
- More than half the days
- Nearly every day

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
- Somewhat difficult
- Very difficult
- Extremely difficult

RISK FOR FALLING

Have you fallen in the past year?

- Yes
- No

Do you use or have you been advised to use a cane or walker to get around safely?

- Yes
- No

Do you sometimes feel unsteady while walking?

- Yes

- No

Do you steady yourself by holding onto furniture when walking at home?

- Yes
- No

Do you worry about falling?

- Yes
- No

Do you need to push with your hands to stand up from a chair?

- Yes
- No

Do you have trouble stepping up onto a curb?

- Yes
- No

Do you often have to rush to the toilet?

- Yes
- No

Have you lost some feeling in your feet?

- Yes
- No

Do you take medicine that sometimes makes you light-headed or more tired than usual?

- Yes
- No

Do you take medicine to help you sleep or improve your mood?

- Yes
- No

Do you often feel sad or depressed?

- Yes
- No


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