NON-MEDICARE ANNUAL WELLNESS VISIT SHEET

NAME: _____ DOB: _____ DATE: _____

Has there been any changes in your medical history since your last visit?

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐Elementary ☐High School ☐ Vocational ☐ College ☐Graduate / Professional

Are there any problems that affect your communication? ☐ Vision Concerns ☐ Hearing Concerns

Are there any limitations to understanding or following instructions (either written or verbal)? ☐ Yes ☐No

Current living situation (Check all that apply): ☐ Single Family Household ☐ Multi-generational Household ☐ Houseless

☐ Shelter ☐ Skilled Nursing Facility ☐ Other:_____

Smoking/Tobacco Use: ☐ Never ☐ Past ☐ Current Type: _____ Amount/Day: _____ Number of Years: _____

Alcohol: ☐ Never ☐ Past ☐ Current Drinks/Week: _____

Recreational Drug Use: ☐ Never ☐ Past ☐ Current Type: _____

Are you sexually active? ☐ Yes ☐No

How would you describe your sexual orientation? ☐ Straight or Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual

☐ Don't Know/Unknown ☐ Choose Not To Disclose

What is your current gender identity? ☐ Male ☐ Female ☐ Transgender Male (female-to-male)

☐ Transgender Female (male-to-female) ☐ Genderqueer (neither exclusively male or female) ☐ Choose Not To Disclose

What sex were you assigned at birth? ☐ Male ☐ Female

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐ Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐ Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐ Yes ☐No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Do you have little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Declined to specify

Have you been feeling down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Declined to specify

Comments (Please feel free to comment on any answers marked above):

_____

_____

Patient Signature: _____