BOUNDARY Community Clinics

ATTACHMENT B

Wellness Visit

Medical Record Number

Patient's name:_____D.O. B____/_____/_____Exam Date: _____

Allergies to Meds:_____1° Care Provider_____

Past personal illnesses, injuries, operations or diagnoses	Date	Hospitalized?

Tobacco use: YES ☐ NO ☐ If yes, (smoke or chew) how many packs per day? _____
Alcohol use: YES ☐ NO ☐ If yes, how many drinks per day? _____
Drug use: YES ☐ NO ☐ If yes, describe _____

Medications, supplements, vitamins Name	Route (ie. Oral, topical, etc.)	Dose	Frequency (ex. 1 – 2 times/day)

Add additional page if further space for Medications is needed

Current list of patient's providers and suppliers

NAME	SPECIALTY	REASON

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Medical Record Number

Family History: particularly Parents, Grandparents, Siblings (check those that apply)

☐ Alcoholism	☐ Cancer	☐ High Cholesterol	☐ Obesity
☐ Arthritis	☐ Diabetes	☐ Hypertension	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Liver or Kidney Disease	☐ Thyroid Disease
Additional History/Notes:			

Number of servings of fruits and vegetables do you have per day? _____

How many times/week do you exercise?_____Duration?_____Type? _____

Hearing loss screen

1. Do you have trouble hearing the TV or radio when others don't? ☐ YES ☐ NO
2. Do you have to strain or struggle to hear/understand conversations? ☐ YES ☐ NO

Function screen

1. Do you need help with preparing meals, transportation, shopping, taking your meds, managing finances, or other activities of daily living? ☐ YES ☐ NO
2. Do you live alone? ☐ YES ☐ NO

Fall Screen

1. Have you had an injury from a fall in the last year? ☐ YES ☐ NO
2. Have you had more then one fall in the last year? ☐ YES ☐ NO

Home safety screen

1. Does your home have rugs, poor lighting, or a slippery bathtub/shower? ☐ YES ☐ NO
2. Does your home LACK grab bars in bathrooms, handrails on stairs or steps? ☐ YES ☐ NO
3. Does your home LACK functioning smoke alarms? ☐ YES ☐ NO

Advanced care planning

1. Patient Consent: "I consent to discuss end-of-life issues with my healthcare provider."

_____ _____

Patient/Guardian Signature Date