Cherokee Internal Medicine, P.C.

Annual Wellness Exam

Name:_____

DOB: _____

1. How is your overall health?
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
2. What are your biggest concerns about managing your health?
   - ☐ None
   - ☐ I live in an unsafe environment
   - ☐ Transportation to appointments
   - ☐ Financial difficulty in paying for services/medicines
   - ☐ I fall a lot at home
   - ☐ Difficulty reading or understanding instructions
   - ☐ I am lonely or don't have a lot of support at home
   - ☐ I am often very tired
   - ☐ I experience a lot of stress or anger
   - ☐ Sexual health issues
3. How many times in the last 6 months have you been to the emergency room?
   - ☐ 0 times
   - ☐ 1-2 times
   - ☐ 3-4 times
   - ☐ 5+ times
   - ☐ I don't know
4. How many times in the last 6 months have you been admitted to the hospital?
   - ☐ 0 times
   - ☐ 1-2 times
   - ☐ 3-4 times
   - ☐ 5+ times
   - ☐ I don't know
5. What kind of diet do you follow?
   - ☐ Keto/Low Carb
   - ☐ Low Cholesterol
   - ☐ Balanced
   - ☐ Diabetic
   - ☐ Gluten-Free
   - ☐ Healthy High Fat
   - ☐ Low Fat
   - ☐ High Calorie
   - ☐ Low Carlorie
   - ☐ Low Sodium
   - ☐ Vegetarian
   - ☐ Lactose Free
   - ☐ None
   - ☐ Other:_____
6. Have you lost 10lbs over 6 months without trying to do so?
   - ☐ Yes
   - ☐ No
7. How often do you exercise?
   - ☐ Never
   - ☐ Daily
   - ☐ Every other day
   - ☐ 3-4 times per week
   - ☐ Weekly
   - ☐ Monthly
8. ADLs: Are you able to perform all ADLs (bathe, dress, eat, walk, transfer in/out of chairs, use the bathroom, etc.) independently?
   - ☐ Yes
   - ☐ No
9. IADLs : Are you able to perform all IADLs (Shop for groceries, Use of telephone, Housework, Handle Finances, Drive/Use Public transportation, Make Meals, Take medications etc.) independently?
   - ☐ Yes
   - ☐ No
10. Does someone help you at home?
    - ☐ Yes
    - ☐ No
    - ☐ Spouse
    - ☐ Children
    - ☐ Other:_____
    - ☐ Aide/Caregiver_#:

11. Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experienced leaking of urine?
    - ☐ Yes
    - ☐ When I cough/sneeze
    - ☐ When I sleep
    - ☐ No
12. Do you have any concerns regarding home safety?
    - ☐ None
    - ☐ No smoke detectors
    - ☐ Lack of railings or unstable railing
    - ☐ Unsafe steps
    - ☐ Poor Lighting
    - ☐ Uneven Flooring
    - ☐ Throw rugs
    - ☐ Other: ___
13. Do you fasten your seatbelt in vehicles?
    - ☐ Yes
    - ☐ No
14. Do you or your family members have any concerns about your memory?
    - ☐ Yes
    - ☐ No
15. Do you see an eye doctor?
    - ☐ Yes
    - ☐ No
16. Have you had any problems with your vision?
    - ☐ Yes
    - ☐ No
17. Do you wear glasses or contacts?
    - ☐ Yes
    - ☐ No
18. Have you had any problems with your hearing?
    - ☐ Yes
    - ☐ No
19. Do you see an audiologist?
    - ☐ Yes
    - ☐ No
20. Do you wear hearing aids?
    - ☐ Yes
    - ☐ No
21. Have you had any problems with your teeth or dentures?
    - ☐ Yes
    - ☐ No
22. Do you have partials or dentures?
    - ☐ Yes
    - ☐ No
23. Do you have an Advanced Directive/Living Will?
    - ☐ Yes
    - ☐ No
24. Have you fallen 2 or more times or have had a fall with injury in the past year?
    - ☐ Yes
    - ☐ No
25. Which of these assistive devices do you use?
    - ☐ None
    - ☐ Cane
    - ☐ Walker
    - ☐ Wheelchair
    - ☐ Crutches
    - ☐ Other: ____
26. Do you have trouble with your balance?
    - ☐ Yes
    - ☐ No
27. Are you afraid of falling?
    - ☐ Yes
    - ☐ No
28. Did you have a drink containing alcohol in the past year?
    - ☐ Yes
    - ☐ No
29. How often did you have a drink containing alcohol in the past year?
    - ☐ Never
    - ☐ Monthly or less
    - ☐ 2 to 4 times a month
    - ☐ 2 to 3 times a week
    - ☐ 4 or more times a week
30. Have you misused prescription drugs or used illicit drugs other than those for medical reasons in the past 12 months?
    - ☐ Yes
    - ☐ No

31. What is your pain level today (0= no pain, 10 = worst pain)?
    0 1 2 3 4 5 6 7 8 9 10
32. Are you taking any prescription opioid for severe pain?
    ☐ Yes ☐ No
33. Are you a:
    ☐ Current Smoker ☐ Light Tobacco Smoker
    ☐ Former Smoker ☐ Heavy Tobacco Smoker
    ☐ NonSmoker
34. Women 50-74 years of age should have a mammogram to screen for breast cancer at least once every 24 months:
    ☐ I am up-to-date ☐ I decline further imaging
    ☐ I am overdue ☐ This doesn't apply to me
35. Patients 50-75 years of age should have an appropriate screening of colorectal cancer:
    ☐ I am up-to-date ☐ N/A
    ☐ I am overdue ☐ I decline this screening
36. Did you get your flu shot this season?
    ☐ Yes ☐ No
37. Have you received a pneumococcal/pneumonia vaccine?
    ☐ Yes ☐ No

Please select yes or now for any symptoms you have experienced in the last 2 weeks.

General/Constitutional

Change in appetite:	Yes	No
Chills:	Yes	No
Fatigue:	Yes	No
Fever:	Yes	No
Weight gain:	Yes	No
Weight loss:	Yes	No

Allergy/Immunology

Watery Eyes:	Yes	No

Ophthalmologic

Blurred vision:	Yes	No
Eye discharge:	Yes	No
Eye pain:	Yes	No

ENT

Decreased hearing:	Yes	No
Ear pain:	Yes	No

Endocrine

Cold intolerance:	Yes	No
Heat intolerance:	Yes	No

Musculoskeletal

Joint stiffness:	Yes	No
Weakness:	Yes	No

Cardiovascular

Chest pain at rest:	Yes	No
Chest pain with exertion:	Yes	No
Difficulty laying flat:	Yes	No
Dizziness:	Yes	No
Fluid accumulation in the legs:	Yes	No
Irregular heartbeat:	Yes	No
Palpitations:	Yes	No

Gastrointestinal

Abdominal pain:	Yes	No
Blood in stool:	Yes	No
Change in bowel habits:	Yes	No
Constipation:	Yes	No
Diarrhea:	Yes	No
Difficulty swallowing:	Yes	No
Nausea:	Yes	No
Vomiting:	Yes	No

Genitourinary

Blood in urine:	Yes	No
Difficulty urinating:	Yes	No
Foul odor:	Yes	No
Frequent urination:	Yes	No
Genital rash:	Yes	No
Genital discharge:	Yes	No

Neurological

Balance difficulty	Yes	No
Difficulty Speaking	Yes	No
Dizziness	Yes	No
Fainting	Yes	No
Headaches	Yes	No
Tingling/Numbness	Yes	No

Psychiatric

Anxiety	Yes	No
Depressed mood	Yes	No
Difficulty sleeping	Yes	No
Stressors:	Yes	No

Respiratory

Cough	Yes	No
Shortness of breath at rest	Yes	No
Shortness of breath with exertion	Yes	No
Wheezing	Yes	No

Skin

Dry Skin	Yes	No	Itching	Yes	No	Mole(s)	Yes	No	Rash	Yes	No

Over the last 2 weeks have you experienced any of the following:	0 Not at all	1 Several Days	2 More than half the days	3 Nearly every day
Little interest or please in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way?				

Date: _____

What is your current housing situation?

- ☐ I have housing
- ☐ I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, or in a park)
- ☐ I choose not to answer this question

Are you worried about losing your housing?

- ☐ Yes
- ☐ No
- ☐ I choose not to answer this question

What is the highest level of school that you have finished?

- ☐ Less than a high school diploma
- ☐ High school diploma or GED
- ☐ More than high school
- ☐ I choose not to answer this question

What is your current work situation?

- ☐ Unemployed and seeking work
- ☐ Part time or temporary work
- ☐ Full time work
- ☐ Otherwise unemployed but not seeking work (ex. student, retired, disabled, unpaid primary care giver)

- ☐ I choose not to answer this question

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply

- ☐ Food
- ☐ Clothing
- ☐ Utilities
- ☐ Child care
- ☐ Medicine or any health care (medical, dental, mental health or vision)
- ☐ Phone
- ☐ Other (please write in notes)
- ☐ I do not have problems meeting my needs
- ☐ I choose not to answer this question

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- ☐ Yes, it has kept me from medical appointments or from getting my medications
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living
- ☐ No
- ☐ I choose not to answer this question

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

- ☐ Less than once a week
- ☐ 1 or 2 times a week
- ☐ 3 to 5 times a week
- ☐ More than 5 times a week
- ☐ I choose not to answer this question

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled

- ☐ Not at all
- ☐ A little bit
- ☐ Somewhat
- ☐ Quite a bit
- ☐ Very much
- ☐ I choose not to answer this question

Do you feel physically and emotionally safe where you currently live?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I choose not to answer this question

In the past year, have you been afraid of your partner or ex-partner?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I have not had a partner in the past year
- ☐ I choose not to answer this question

Think about the place you live. Do you have problems with any of the following? (check all that apply)

- ☐ Bug Infestation
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Inadequate heat
- ☐ Oven or stove not working
- ☐ Water leaks
- ☐ N/A