Graybill Medical Group
Annual Wellness Visit

Section 1.0: Beneficiary Demographics

Today's Date:

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: _____

Preferred Telephone: _____

Are you of Hispanic, Latino or Spanish origin?

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

Which race best describes you?

☐ American Indian or Alaskan Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American ☐Black or African American ☐ White

Section 2.0: List of other providers and suppliers

To ensure optimal care coordination, please provide a list of physicians, behavioral health providers and medical equipment suppliers you are using and the reason below:

Name of Provider	Specialty	Reason

Patient's Name: _____ DOB: _____

Section 3.0: Health Risk Assessment

1. In general, how would you rate your health?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
2. In general, how would you rate your quality of life?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
3. In general, how would you rate your mental health, including your mood and your ability to think?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
4. Have you had a flu shot this year? ☐ Yes ☐ No
5. Have you been to the ER or had any hospitals stays within the last year? ☐ Yes ☐ No
6. Have you been having any problems with your hearing? ☐ Yes ☐No
7. When was the last time you had the following:

	Within the last year	In the last 2-4 years	In the last 5 years	In the last 10 years	Never	Not Applicable
Pneumonia Vaccine:	☐	☐	☐	☐	☐	☐
Breast Cancer Screening (Mammogram):	☐	☐	☐	☐	☐	☐
Colorectal Cancer Screening (Colonoscopy):	☐	☐	☐	☐	☐	☐
Bone Density Screening (Dexa Scan)	☐	☐	☐	☐	☐	☐

Section 4.0: Functional Ability

8. Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person?
   ☐Declined to answer

	I do not have difficulty	Yes, I have difficulty	I am not able to do this activity unassisted
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Using the toilet	☐	☐	☐
Getting in and out of bed or chairs	☐	☐	☐
Remembering to take medications	☐	☐	☐
Managing money or financial information	☐	☐	☐
Household activities like food prep laundry and housekeeping	☐	☐	☐

Patient's Name: _____ DOB: _____

	I do not have difficulty	Yes, I have difficulty	I am not able to do this activity unassisted
Shopping for groceries and clothes	☐	☐	☐
Getting to places out of walking distance	☐	☐	☐

9. Did you fall within the last year? ☐ Yes ☐ No ☐Declined to answer
    a. If Yes:
        i. How many times: _____
        ii. Were you injured? ☐ Yes ☐ No
10. Do you feel unsteady when walking or standing? ☐ Yes ☐ No

Section 5.0: Social Determinants of Health

11. What is your living situation today?
    ☐ I have a steady place to live
    ☐ I have a place to live today, but am worried about losing it in the future
    ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, etc.)
    ☐Declined to answer

12. Think about the place where you live. Do you have any problems with any of the following? (Choose all that apply)
    ☐ Pests such as bugs, ants or mice
    ☐ Mold
    ☐ Lead paint or pipes
    ☐ Lack of heat
    ☐ Oven or stove not working
    ☐ Smoke detectors missing or not working
    ☐ Water leaks
    ☐ None of the above
13. Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES or NEVER true for you and your household in the last 12 months:
    ☐Declined to answer

	Often	Sometimes	Never
Within the last 12 months, you worried that your food would run out before you got money to buy more	☐	☐	☐
Within the last 12 months, the food you bought just didn't last and you didn't have money to get more.	☐	☐	☐

Patient's Name: _____ DOB: _____

14. Within the last 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or getting the things needed for daily living?
    ☐ Yes ☐ No
15. In the last 12 months has the electric, gas, oil or water company threatened to shut off services in your home?
    ☐ Yes ☐ No ☐ Already shut off
16. Because violence and abuse happens to a lot of people and affects their health we are asking the following questions:
    ☐Declined to answer

	Never	Rarely	Sometimes	Fairly Often	Frequently
How often does anyone, including family and friends, physically hurt you?	☐ +1	☐ +2	☐ +3	☐ +4	☐ +5
How often does anyone, including family and friends, insult or talk down to you?	☐ +1	☐ +2	☐ +3	☐ +4	☐ +5
How often does anyone, including family and friends, threaten you with harm?	☐ +1	☐ +2	☐ +3	☐ +4	☐ +5
How often does anyone, including family and friends, scream or curse at you?	☐ +1	☐ +2	☐ +3	☐ +4	☐ +5

Score: _____

**A score of 11 or more indicates that the person might not be safe.*

17. How hard is it for you to pay for the very basics like food, housing, medical care and heating?
    ☐ Very hard ☐ Somewhat hard ☐ Not hard at all ☐Declined to answer
18. Do you want help finding or keeping work or a job?
    ☐ Yes, help finding work ☐Yes, help keeping work ☐ I do not want or need help
19. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?
    ☐ I don't need any help ☐ I could use a little more help
    ☐ I get all the help I need ☐ I need a lot more help
20. How often do you feel lonely or isolated from those around you?
    ☐ Never ☐ Rarely ☐ Sometimes
    ☐ Often ☐ Always
21. Do you speak a language other than English at home?
    ☐Yes ☐No

Patient's Name: _____ DOB: _____

22. Do you want help with school training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.
    ☐Yes ☐No
23. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)? _____
24. On average, how many minutes did you usually spend exercising at this level on one of those days? _____
25. How many servings of fruits and vegetables do you eat in a typical day?
    ☐ More than 5 servings ☐ 3-5 Servings ☐ 1-2 Servings ☐ I do not eat fruits and vegetables
26. Do you wear a seatbelt when driving in a motorized vehicle? ☐ Yes ☐ No
27. The next questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances are prescribed by a doctor (like pain medications), but only count those if you have taken them for reasons or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask to identify community services that may be available to help you.
    ☐Declined to answer

	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine or 1.5 ounces of 80-proof spirits)	☐	☐	☐	☐	☐
How many times in the past 12 months have you used tobacco products? (Cigarettes, cigars, snuff, chew or electronic cigarettes)	☐	☐	☐	☐	☐
How many times in the past year have you used prescription drugs for non-medical reasons?	☐	☐	☐	☐	☐
How many times in the past year have you used illegal drugs?	☐	☐	☐	☐	☐

28. Stress means a situation in which a person feels tense, restless, nervous or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?
    ☐ Not at all ☐ Somewhat ☐ Very Much
    ☐ A little bit ☐ Quite a bit
29. Because of physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?
    ☐ Yes ☐No ☐Declined to answer

Patient's Name: _____ DOB: _____

30. Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
☐ Yes ☐ No ☐Declined to answer

Section 6.0: Depression Screening

31. Over the last two weeks how often have you been bothered by the following problems?
☐Declined to answer

	Not at all	Several Days	More than half the days	Nearly everyday
Little interest or pleasure in doing things?	☐ 0	☐ +1	☐ +2	☐ +3
Feeling down, depressed or hopeless	☐ 0	☐ +1	☐ +2	☐ +3

Score: _____

**If score is 3 or greater, clinical support staff should administer PHQ-9*

Section 7.0 Opioid Use Disorder Screening

32. Are you currently taking any illicit drugs? ☐ Yes ☐ No ☐Declined to answer
33. Are you currently taking any prescribed opiates? ☐ Yes ☐ No ☐Declined to answer

**If patient answers yes to question 32 or 33 then administer the Opiate Use Disorder Questionnaire*

Section 8.0 Advanced Care Planning

34. Do you have an advanced directive in place? ☐ Yes ☐No

Section 9.0 Timed Up and Go Scoring

To be completed by the nurse or medical assistant during the office visit

TUG Test Result *An older adult who takes more than 12 seconds to complete the TUG is at risk for falling.*
Time in seconds: _____

Section 10.0 Mini Cognitive Exam Scoring

To be completed by the nurse or medical assistant during the office visit

Scoring **Note:** A score of 3 or less should trigger further evaluation by the care provider, such as a Mini Mental State Examination

Patient's Name: _____ DOB: _____

Word Recall (0-3 points): _____	1 point for each word spontaneously recalled without cueing.
Clock Draw (0 or 2 points): _____	Normal clock= 2 points. A normal clock has all numbers placed in the correct sequence and approximately correct position with no missing or duplicate numbers. Hands are pointing to the 11 and 2. Hand length is not scored. Inability or refusal to draw the clock= 0 points.
Total Score (0-5 points):_____	Total score= Word recall score + clock draw score. A cut point of <3 on the mini-cog has been validated for dementia screening but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of <4 is recommended as it may indicate a need for further valuation of cognitive status.

Physician Acknowledgment Statement:

I acknowledge that I have reviewed the patient's information provided in this Annual Wellness Visit packet and any other relevant documentation. I confirm that this information has been considered in the development of the patient's care plan.

Physician's Name: _____ Date: _____

Physician's Signature: _____