



# 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 hospital 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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer Screening (Mammogram):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Cancer Screening (Colonoscopy):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bone Density Screening (Dexa Scan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in and out of bed or chairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remembering to take medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing money or financial information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household activities like food prep laundry and housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting to places out of walking distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 5.1: Physical Activity Vital Sign

11. In a typical week, how many days do you engage in moderate to strenuous physical activity (like brisk walking)?

0 Days  1-2 days  3-4 days  5+ days

12. On average, how many minutes did you usually spend exercising at this level on one of those days?

0-10 mins  11-20 mins  21-30 mins  31+ mins

Score: \_\_\_\_\_

### Section 5.2: Nutrition Assessment

13. How often do you eat fast food or takeout meals?

Never  1-2 times per week  3+ times per week

14. How many servings of fruits and vegetables do you eat daily?

0-1 Serving  2-3 Servings  4+ Servings

15. How often do you eat high-fat foods (fried food, butter, full-fat dairy)?

Never  Occasionally  Daily

16. How often do you drink sugary beverages (soda, juice, energy drinks)?

Never  Occasionally  Daily

17. How often do you eat red or processed meat?

Never  1-2x Per Week  3+ times per week

18. How often do you eat whole grains?

Most of the time  Sometimes  Never

19. How often do you add salt to your food?

Never  Sometime  Often

20. How often do you eat breakfast?

5-7 days per week  3-4 days per week  0-2 days per week

Score: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Section 6.0: Depression Screening**

21. 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?	<input type="checkbox"/> 0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3
Feeling down, depressed or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> +1	<input type="checkbox"/> +2	<input type="checkbox"/> +3

Score: \_\_\_\_\_

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

**Section 7.0 Opioid Use Disorder Screening**

22. Are you currently taking any illicit drugs?  Yes  No  Declined to answer

23. 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**

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

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### 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

#### **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: \_\_\_\_\_