**ANNUAL WELLNESS VISIT UPDATE FORM-** ***Please bring completed form to your appointment. Thank You.***

| Name | Date of Birth | Date of Last Visit | Date of This Visit |
|---|---|---|---|

✓ **Please list screening tests and immunizations you've received outside this office since your last office visit.**

| | | |
|---|---|---|
| Flu Vaccine | Date: | Facility: |
| Pneumonia Vaccine | Date: | Facility: |
| Tdap | Date: | Facility: |
| Shingles Vaccine | Date: | Facility: |
| Other Injections | Date: | Facility: |
| Colonoscopy | Date: | Facility: |
| Mammogram | Date: | Facility: |
| DEXA Bone Density | Date: | Facility: |
| Vision Exam | Date: | Physician/Place: |
| Foot Exam | Date: | Physician/Place: |

✓ **Please list any ER visits, hospitalizations or surgeries since your last office visit.**

| Reason | Date | Facility |
|---|---|---|

✓ **Please list any diagnostic tests such as Blood test, X-rays, MRI or CT scans since your last office visit.**

| | | |
|---|---|---|
| Test | Date | Facility: |
| Test | Date | Facility: |

✓ **Please list any specialists you have seen since your last office visit.**

| | | |
|---|---|---|
| Name | Date | Phone |
| Name | Date | Phone |

✓ **General health updates**

| | YES | NO |
|---|---|---|
| Have you had any falls resulting in injury in the past year? | | |
| Do you feel unsteady on your feet? | | |
| Current tobacco use? | | |
| Do you need help with routine tasks such as preparing meals, managing medications or other? | | |
| Have you established a Living Will? | | |

| | | | | |
|---|---|---|---|---|
| Alcohol Use? | None | Rare | 2-5 per week | 6 or more per week |
| Exercise 20 min or more? | Yes, several times a week | No, not usually | | |

✓ **Depression Screening- Over the last two weeks have you been bothered by:**

| | | | | |
|---|---|---|---|---|
| Little or no interest in doing things? | Never | Sometimes | Often | Always |
| Feeling down, depressed or hopeless? | Never | Sometimes | Often | Always |