Your Wellness Visit Guide

Fill it out. Take it with you.

Last Name:	
First Name:	
Date of Birth:	Today's Date:

For each question, select the answer that best describes you.

General Health:

How would you rate your general health?

Overall health

___ *Excellent* ___ *Very good* ___ *Good* ___ *Fair* ___ *Poor*

Physical health (compared to last year)

___ *Much better* ___ *Slightly better* ___ *Same* ___ *Slightly worse* ___ *Much worse*

Eyesight (compared to last year)

___ *Same* ___ *Slightly worse* ___ *Much worse*

Hearing (compared to last year)

___ *Same* ___ *Slightly worse* ___ *Much worse*

Emotional/mental health (compared to last year)

___ *Much better* ___ *Slightly better* ___ *Same* ___ *Slightly worse* ___ *Much worse*

Pain: In the past 7 days, how much pain have you experienced?

___ *None* ___ *Some* ___ *A lot*

If you answered *"Some"* or 'A *lot,"* please rate the severity of your pain on a scale of 1 to 10. (1 being the least severe pain and 10 being the most intense pain; circle one)

1 2 3 4 5 6 7 8 9 10

Weight: In the past 6 months, have you lost or gained 10 pounds without trying?

___ *Yes* ___ *No*

To Be Completed By Your Health Provider

Height: _____ Weight: _____ BMI: _____

Your Name:	DOB:	Date:

Emotional/Mental Health:

During the past month:

Have you often felt down, depressed, or hopeless?	___ Yes	___ No
Have you often had little interest or pleasure in doing things?	___ Yes	___ No
Have you felt nervous, anxious or on edge?	___ Yes	___ No

Broken Bones/Falls:

Have you:

Broken a bone?	___ Yes	___ No
Had a bone mineral density test?	___ Yes	___ No
Fallen within the past year?	___ Yes	___ No
If you have fallen within the past year, how many times?		

Bladder/Bowel:

In the past six months, have you accidentally leaked urine?	___ Yes	___ No
Do you have problems with loss of bowel control?	___ Yes	___ No

Immunizations:

Have you had a flu vaccination within the past year?	___ Yes	___ No
Have you had a pneumonia shot?	___ Yes	___ No
Have you had a shingles vaccination?	___ Yes	___ No
When was your last tetanus/diphtheria shot? Date:		

Home Safety:

Do you have trouble with the stairs inside or outside your home?	___ Yes	___ No
Do you have hazards inside the home such as a lack of grip bars in the bathtub, loose rugs, or poor lighting?	___ Yes	___ No
Does your home have working smoke alarms?	___ Yes	___ No
Does your home have a carbon monoxide monitor?	___ Yes	___ No

Your Name:	DOB:	Date:

Preventive Screenings:

Have you had any of the following screenings?

Breast cancer (women only)	___ *Yes*	___ *No*	*Date:* _____
Prostate cancer (men only)	___ *Yes*	___ *No*	*Date:* _____
Colon cancer	___ *Yes*	___ *No*	*Date:* _____
Cholesterol	___ *Yes*	___ *No*	*Date:* _____
Glaucoma eye exam	___ *Yes*	___ *No*	*Date:* _____

Nutrition:

In the past 7 days:

How many servings of fruits and vegetables did you typically eat each day?	_____*serving(s)/day*
How many servings of high-fiber foods or whole grains did you typically eat each day?	_____*serving(s)/day*
How many servings of fried or high-fat foods did you typically eat each day?	_____*serving(s)/day*
How many sugar-sweetened beverages did you typically consume each day?	_____*serving(s)/day*

Medications:

Do you understand why you're prescribed your medications?	___ *Yes*	___ *No*
Are you taking your medications as directed by your doctor?	___ *Yes*	___ *No*
Do you experience any side effects from your medications?	___ *Yes*	___ *No*
If yes, what are _____		
From which drug(s)? _____		
Are you concerned about the cost of your medications?	___ *Yes*	___ *No*
In addition to prescription medications, are you taking any over-the-counter supplements?	___ *Yes*	___ *No*
If yes, what are _____		
Do you ever forget to take your medications?	___ *Yes*	___ *No*

Your Name:	DOB:	Date:

Lifestyle

Do you currently smoke or use other tobacco products? ___ *Yes* ___ *No*

Have you smoked or used other tobacco products in the past? ___ *Yes* ___ *No*

If yes, have you stopped? _____

Do you drink alcohol? ___ *Yes* ___ *No*

If yes, how many drinks per

Do you drive? ___ *Yes* ___ *No*

Do you use seat belts? ___ *Yes* ___ *No*

Describe your level of exercise or physical activity: _____

Activities of Daily

Can you:

Get out of bed by yourself? ___ *Yes* ___ *No*

Dress yourself? ___ *Yes* ___ *No*

Make your own meals? ___ *Yes* ___ *No*

Do your own shopping? ___ *Yes* ___ *No*

Bathe yourself? ___ *Yes* ___ *No*

Do your laundry/housekeeping? *Yes* *No*

Manage your money, pay your bills, and track your expenses? *Yes* *No*

List of Health

Please list any doctors or other health providers you have seen over the past year and the medical problems that were/are being treated.

DOCTOR/HEALTH PROVIDER NAME:	SPECIALTY:	REASON:

Your Name:	DOB:	Date:

Hospitalizations and Emergency Room Visits in the Past Year:

DATE OF VISIT:	REASON:

Advance Directives:

Have you decided who would speak for you and make health care treatment choices for you if you became ill and could not make them for yourself?	___ Yes ___ No
If you answered yes to the question above, have you spoken to that person about your choices?	___ Yes ___ No
Have you completed a written advance directive (that is, a living will and/or health care power of attorney)?	___ Yes ___ No

Social Support:

Do you have someone who helps you manage your health care, like a friend or family member?
If yes, please provide their contact information.

Health Contact Name:		
Street Address:		
City	State	Zip Code
Telephone *(with area code)*		

Your Name:	DOB:	Date:

Great job!

You've completed your guide. Now take it with you to your appointment.

Thank you for filling out this guide. You should feel good about being proactive! Following through with preventive care is one of the best things you can do for your well-being.

Your health is important. Highmark, your doctor and your other health providers are here to help protect it with the resources, information and personal support you need.

Be sure to bring this completed guide to get the most from your Wellness Visit.

Reminder:

Take all medications or a list of all medications with you to your Wellness Visit. This includes:

- Prescription drugs
- Drugs that you purchase over the counter
- All vitamins and supplements
- Substances that you place on your body, such as ointments or patches

For Office Use Only	
Physician Signature:	Date:

Please place a copy of this assessment in the patient's chart or medical record.