Adult Annual Visit

MRN_____ **Today's Date** _____

Name_____ **Date of Birth**_____

List anyone else involved with your care including other medical providers:

_____

_____

SOCIAL HISTORY:

Marital Status: _____ **Do you have an Advance Directive? YES/NO**

Are you currently employed? YES / NO -- Occupation: _____

Describe your current physical activities: _____

Describe your current diet: _____

Tobacco Use:

Have you smoked tobacco within the last 30 days?.....YES/NO Never: _____

Former Smoker: _____ How Many? _____ Quit When? _____

Current Smoker: _____ How Many? _____ How Long? _____

Interest in Quitting? YES / NO

Alcohol Use: How many drinks per week? _____

Alcohol: One drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or More
MEN: How many times in the past year have you had 5 or more drinks in a day?		
WOMEN: How many times in the past year have you had 4 or more drinks in a day?		

Recreational Drug Use:

Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

Are you currently using or have you ever used recreational drugs? YES / NO

If yes, what kind? _____ **For how long?**_____

DEPRESSION SCREENING:

Over the last 2 weeks, how often have you been bothered by any of the following:

	Not At All	Several Days	More Than Half The Days	Nearly Every Day
	0	**1**	**2**	**3**
1. Little interest or pleasure in doing things:				
2. Feeling down, depressed or hopeless:				

ALLERGIES: (Please list any food or drug allergies)

_____

CURRENT MEDICATIONS: (Please include supplements and non-prescription medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

FAMILY HISTORY:

Have your parents, brothers, sisters or children ever been treated for (circle yes or no):

Cancer…… YES / NO Who? _____

Nervous Disorders……..…. .YES / NO Who? _____

Diabetes……....YES / NO Who? _____

High Blood Pressure…… YES / NO Who?_____

Heart Disease…… YES / NO Who?_____

Blood Disease ……..…… YES / NO Who?_____

HISTORY OF MEDICAL CARE:

Last Eye Exam: _____

Last Colon Cancer Screening:_____

For women:

Last Pap Smear:_____

Last Mammogram:_____

If you are 5o years old or under: Would you like to become pregnant in the next year?.....YES/NO

Current method of birth control: _____

PAST MEDICAL HISTORY:

Have YOU ever been treated for (circle yes or no):

Cancer…… YES / NO
Nervous Disorders……..…. YES / NO
Heart Disease…….…... YES / NO
Muscular Disorder…….. YES / NO
Glaucoma……... YES / NO
High Blood Pressure…… YES / NO
Hay Fever or Asthma…….. YES / NO
Blood Disease……. YES / NO
Kidney Trouble……. YES / NO
Diabetes…….…….. YES / NO

PAST SURGICAL HISTORY: (Please list all major surgeries)

_____

_____

_____

HISTORY OF ILLNESSES AND CHRONIC MEDICAL PROBLEMS:

_____

_____

_____

_____

REVIEWED BY: _____

DATE:_____

Functional Ability & Safety

MRN_____ **Today's Date** _____

Name _____ **Date of Birth** _____

General Health & Wellness

In general, how would you rate your health?

Excellent ____ **Very Good** ____ **Good** ____ **Fair** ____ **Poor** ____

Activities of Daily Living

While performing the following activities are you: Independent (I) can do task without assistance, Require Assistance (A) need help from another person, or Dependent (D) cannot perform task at all?

Walking	**I**	**A**	**D**		**Using Telephone**	**I**	**A**	**D**
Dressing	**I**	**A**	**D**		**Shopping**	**I**	**A**	**D**
Bathing	**I**	**A**	**D**		**Preparing Meals**	**I**	**A**	**D**
Eating	**I**	**A**	**D**		**Housework**	**I**	**A**	**D**
Toileting	**I**	**A**	**D**		**Taking Medications**	**I**	**A**	**D**
Driving	**I**	**A**	**D**		**Managing Finances**	**I**	**A**	**D**

Adult Review of Symptoms

Have you experienced any recent changes to your vision?	**Yes**	**No**
Have you experienced any recent changes to your hearing?	**Yes**	**No**
Have you noticed any recent changes to your memory?	**Yes**	**No**
Are you sexually active?	**Yes**	**No**
Do you use a cane or walker?	**Yes**	**No**
Do you feel safe at home?	**Yes**	**No**
Do you have an Advanced Directive?	**Yes**	**No**

Fall Screening

Have you had any falls in the past year? YES / NO

If yes, how many falls? _____ **Were there any injuries from the fall(s)?** _____

Who lives at home with you? _____

Who would help you in an emergency?_____

What is your system for taking your medications?

Pill Box_____ **Family Help**_____ **List or Chart**_____ **None**_____

Reviewing Physician: _____ **Date:**_____