DESERT EDGE MEDICAL

1664 S Dixie Drive Suite D102, St. George, UT 84770

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Name: **Date of Birth:** **Today's Date:**

ANNUAL WELLNESS VISIT ASSESSMENT

To help us understand your overall well-being, we gather important information about your health at each appointment. Thank you for answering these questions in preparation for your visit!

1. How would you rate your overall health? (Check one)

Excellent Good Fair Poor Very Poor

2. Please answer YES or NO to the following:

A.	Are you feeling increased stress?	Yes	No
B.	Are you experiencing Social Isolation?	Yes	No
C.	Are you a current smoker?	Yes	No
D.	Are you exposed to second-hand smoke?	Yes	No
E.	Do you lack a balanced diet?	Yes	No
F.	Is your access to food/nutrition **inadequate?**	Yes	No
G.	Do you drink 4 or more alcoholic drinks in a day?	Yes	No
H.	Do you engage in recreational drug use?	Yes	No

3. Are you able to bathe, walk, and use the toilet without assistance? (Check all that apply)

Yes No

If No, which activities require assistance? (Please check all that apply)

Bathing Walking Using Toilet

4. Are you able to go shopping, do housekeeping, handle finances, and take medications w/o assistance?

Yes No

If No, which activities require assistance? (Please check all that apply)

Shopping Housekeeping Handling Finances Taking Medications

OFFICE USE ONLY: Scanned_____Entered_____

5. Does someone help you at home? (Check all that apply)

Yes No

If Yes, please provide Caregiver Name.

Spouse:__________ Children:__________ Other:__________

6. How often do you exercise for at least 20 minutes 3 or more time a week? (Check one)

Most of the time Some of the time Less Frequently Not at all

7. Have you fallen in the last year?

Yes No

8. Do you feel unsteady when standing or walking?

Yes No

If Yes, which of these assistive devices do you use? (Please check all that apply)

Cane Walker Wheelchair Crutches

Other:__________ None

9. Over the past 2 weeks, how often have you been bothered by any of the following problems? (Check one)

	Not at all	Several days	More than half days	Nearly every day
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless.	0	1	2	3

****NOTE: If you checked 1 or higher on either question there is an additional form for you to fill out. Please let the front desk know if you need one.**

10. During the past 12 months, how often has confusion or memory loss interfered with your ability to work, volunteer, or engage in social activities?

Always Usually Sometimes Rarely Never

11. Do you have any problems with your vision? (Check all that apply)

No vision problems Wear Glasses/Contacts Legally Blind Assistance needed with vision problems

Other:__________

12. Do you have any problems with your hearing? (Check all that apply)

No problems

Partial Loss

Deaf

TTY Used

Assistance needed with hearing problems

Use assistive devices: ______________________

Other: ______________________

13. Does your family or friends know what you want in an emergency situation or if you could not speak for yourself? (If you have any of the following, it would be helpful to have a copy provided to us for your medical record)

Yes, I have a **living will**

Yes, I have a **Power of Attorney**

Yes, I have a **MOLST** (Medical Orders for Life-Sustaining Treatment)

Yes, I have a **POLST** (Provider Orders for Life-Sustaining Treatment)

Yes, I have **completed 5 wishes**

No, but I am interested

No, and I do want one at this time

14. Please list current medical providers. (This includes all specialists)

Provider	Specialty

15. Personal Preventive Plan Services (PPPS) Check each item that has been done and enter the date (Mo./Yr.) when it was last done:

VACCINATIONS & IMMUNIZATIONS

Flu Shot

Yes:______________ No

COVID-19 Vaccine

Yes:______________ No

Pneumonia Shot

Yes:______________ No

Tetanus Shot

Yes:______________ No

Zoster-Shingles

Yes:______________ No

SCREENINGS:

Bone Density Scan

Yes:______________ No

Colonoscopy

Yes:______________ No

AAA Screening (Abdominal Aortic Aneurysm)

Yes:______________ No

Eye Exam

Yes:______________ No

DIABETIC REVIEW:

Retinal Eye Exam

Yes:______________ No

Diabetic Foot Exam

Yes:______________ No

Urinalysis - Creatinine/Albumin

Yes:______________ No

Hemoglobin A1C

Yes:______________ No

WOMEN ONLY:

Mammogram

Yes:______________ No

Pap Smear

Yes:______________ No

MEN ONLY:

Prostate-specific antigen (PSA - Blood Test

Yes:______________ No