



# DESERT EDGE MEDICAL

1664 S. DIXIE DR., STE- 102, ST. GEORGE, UT 84770  
PH: (435) 656-2995 FAX: (435) 656-3237

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?                    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| B. Are you experiencing Social Isolation?               | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| C. Are you a current smoker?                            | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| D. Are you exposed to second-hand smoke?                | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| E. Do you lack a balanced diet?                         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| F. Is your access to food/nutrition <u>inadequate</u> ? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| G. Do you drink 4 or more alcoholic drinks in a day?    | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| H. Do you engage in recreational drug use?              | <input type="checkbox"/> YES | <input type="checkbox"/> 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

**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? (Circle 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 marked 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 not 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 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