Blossomwood Medical
primary care for adults

What exactly is an Annual Wellness Visit?

This visit is encouraged by not only your doctor but your insurance company as a visit that allows you and your doctor to discuss your medical history, review your risk factors, and make a personalized prevention plan to keep you healthy. This visit does not normally include a hands-on exam or any new or current medical problems, conditions, or medications unless the doctor feels that it needs to be addressed at the time of the visit. This visit does require lab work to be drawn prior to the visit.

What is the cost of an Annual Wellness Visit?

Since insurances encourage this visit, **most** insurance companies will cover the cost so no copay is due at the time of the visit. If there are issues that need to be addressed during the visit that do not relate to the Wellness Visit, a bill will be incurred.

What do I need to bring to the visit?

1. A complete comprehensive list of medications being taken or the bottles themselves. This will included prescribed along with over the counter medications.
2. A completed Annual Wellness Visit Questionnaire (can be given to the office at the time of the labs being drawn).
3. A completed Advance Directive and/or Do not resuscitate.
4. A list of current doctors.
5. A list of questions / concerns that you feel should be discussed with Dr. Pukis.

2021 Annual Wellness Visit Questionnaire

Please fill out this form in its entirety to the best of your ability. Completion of the form will help the appointment progress faster and more effectively.

Name: _____ Date of Birth: _____

Please circle whether any member of your family has suffered from any of the following:

Family History

Cancer	Father	Mother	Children	Siblings	Grandparents
Type of Cancer					
Dementia	Father	Mother	Children	Siblings	Grandparents
Depression	Father	Mother	Children	Siblings	Grandparents
Diabetes – Type I	Father	Mother	Children	Siblings	Grandparents
Diabetes – Type II	Father	Mother	Children	Siblings	Grandparents
Heart Disease	Father	Mother	Children	Siblings	Grandparents
High Lipids	Father	Mother	Children	Siblings	Grandparents
Hypertension	Father	Mother	Children	Siblings	Grandparents

General Assessment

			When?
Have you had the flu vaccine this year?	Yes	No	_____
Have you ever had a pneumonia vaccine?	Yes	No	_____
Have you ever had a shingles vaccine?	Yes	No	_____
Have you ever had a positive COVID-19 test?	Yes	No	_____
Have you had the COVID-19 vaccine?	Yes	No	_____
Have you had a Cologuard or Colonoscopy?	Yes	No	_____
Have you ever had a Mammogram	Yes	No	_____
Have you had a Cervical Cancer Screening?	Yes	No	_____
Have you had a prostate exam in the past year?	Yes	No	_____

Please circle the number on the pain scale that addresses your overall pain throughout your daily life:

(None) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Where is the pain located and for how long? _____

Do you have an Advanced Directive / Living Will on file with us? Yes No

What is your marital status? Single Married Divorced Widowed

How do you live?

Alone Spouse Family Assisted Living Nursing Home

What is the highest grade or level of school that you completed?

8th grade or less	Some high school (did not graduate)
High school graduate / GED	Some college
2 year degree	4 year
Masters	Doctorate

Consulting Physicians:

Please list all other physicians that are currently providing health care for you (please include your dentist and eye doctor as well).

Physician:	_____	Type:	_____
Physician:	_____	Type:	_____
Physician:	_____	Type:	_____
Physician:	_____	Type:	_____
Physician:	_____	Type:	_____
Physician:	_____	Type:	_____

Do you have any current concerns in regards to your health that you feel need to be addressed at today's wellness visit? _____

_____

_____

Health Review

General Questions

Would you consider yourself to be in frail or in poor health?	Yes	No
Have you recently lost weight without trying?	Yes	No
In the past year, have you fallen or been injured from a fall?	Yes	No
How many times have you fallen in the past year? _____		
How does your current physical health compare to last year?	Better	Same Worse
How does your current mental health compare to last year?	Better	Same Worse

Hearing Questions

Do you currently have any problems hearing?	Yes	No
If you have hearing problems, do you find it difficult to follow a conversation in a noisy restaurant or crowded room?	Yes	No
Do you feel people are mumbling or not speaking clearly?	Yes	No
Do you experience ringing or noises in your ears?	Yes	No
Do you hear better with one ear than the other?	Yes	No
If you answered yes to the above question which one?	Left	Right
Do you wear hearing aids?	Yes	No

Environmental Questions

Place of Residence – Home / Assisted Living / Memory Care / Nursing Home:

Do you have rails in your home?	Yes	No
Do you have locks on your doors?	Yes	No
Do you have scatter / area rugs on the floor?	Yes	No
Do you have a list of emergency numbers?	Yes	No
Do you have night lights in your home?	Yes	No
Do you have guns in the home?	Yes	No

Medication and Drug Review

Over the past 2 weeks, were there any days that you did not take your medicine as prescribed? Yes No

How often do you miss doses of your medicine?

Never A few times / year A few times / month A few times / week

Which factor keeps you from taking your medicine as directed?

- Forgetfulness
- Side effects
- Cost
- Do not understand the directions
- Do not think the medication is helping
- Do not feel that the medication is necessary
- Other: _____

Are you allergic to any medications or food? Yes No If yes, please list them along with the side effects? _____

_____

List of Current Medications:

Medication	Dosage	How often?	Prescribed by	Reason for taking

Medication	Dosage	How often?	Prescribed by	Reason for taking

Patient Depression Questionnaire

NAME: _____ **DOB:** _____

DATE OF TEST: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleep too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Add Columns	_____	_____	_____	
TOTAL	_____			

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely Difficult**

Tobacco Use Questionnaire

Patient Name: _____ DOB: _____ Date: _____

Smoking History

1. At what age did you **begin** to smoke? _____
2. How many cigarettes do you smoke **before** starting the work day? _____
3. How many cigarettes do you smoke **during** the work day? _____
4. How many cigarettes do you smoke **after** the work day? _____
5. What is the **total** number of cigarettes smoked **per day**?
6. What is the **total** number of cigarettes smoked **per day on the weekend**? _____
7. How many cigarettes have you smoked per day during your **heaviest** smoking period? _____

8. How many times have you tried to stop smoking? (Please circle one)

Never
One
Two
Three
Four
Five
Six or more

9. What is the longest period of time you have gone without smoking since you first started smoking since you first started smoking regularly? (Please circle one.)

1 week or less
1 week to 1 month
2 months to 6 months
7 months to 1 year
Longer than 1 year

10. Have you ever tried to stop smoking before using the following methods? (Please circle all that apply.)

Clinic or group
Written materials
Cold turkey
Gradual reduction
Special filters
Stop with a friend (buddy system)
Hypnosis
Self-help program
Medications _____

Current Plan to Stop Smoking

1. How interested are you in stopping smoking? (Please circle one.)

   Strongly
   Very
   Somewhat
   A little
   Not at all

2. If you decide to quit smoking completely, during the next two weeks, how confident are you that you will succeed? (Please check one.)

   Strongly
   Very
   Somewhat
   A little
   Not at all

3. Do the following people smoke?

   Family (those living with you)
   Friends
   Coworkers

4. Are family members (**encouraging / discouraging**) you from trying to stop smoking? (Please circle one)

From a scale from 1 to 10, please rate your desire to quit smoking.

1	2	3	4	5	7	8	9	10
Not at all								ready to stop today

_____ _____

Signature **Date**

ADL'S

Please circle the correct answer. If you are completely independent and do not need any help please circle the choice for completely independent.

	0	1	2	3
Bowels	Incontinent / constipated	Occasional accident (once a week)	Continent	
Bladder	Incontinent or catheterized and unable to manage	Occasional accident (max once per day)	Continent (for over 7 days)	
Toilet use	Dependent	Needs some help, but do some things alone	Independent	
Grooming	Needs help with personal care	Independent		
Dressing	Dependent	Needs help but can do about half unaided	Independent	
Bathing	Dependent	Independent		
Feeding	Unable	Needs some help	Independent	
Transfer	Unable	Major help (one or two people), can sit	Minor help (verbal or physical)	Independent (but may use any aid)
Mobility	Immobile	Wheelchair independent, including corners	Walks with help of one person (verbal or physical)	Independent
Stairs	Unable	Needs help (verbal, physical, carrying aid)	Independent	
			Completely independent – no issues at all.	
TOTAL				

IADL's

Please circle the correct number using the following scoring system.

SCORING SYSTEM	
Dependent	**3**
Requires assistance	**2**
Has difficulty but does it by themselves	**1**
Normal	**0**
Never did the activity but can now	**0**
Never did and would have difficulty now	**0**

Writing checks, paying bills, balancing checkbook	3	2	1	0
Assembling tax records, business affairs, or papers	3	2	1	0
Shopping alone for clothes, household necessities, or groceries	3	2	1	0
Playing a game of skills, working on a hobby	3	2	1	0
Heating water, making a cup of coffee, turning off stove after use	3	2	1	0
Preparing a balanced meal	3	2	1	0
Paying attention, understanding, discussing TV, book, and magazines	3	2	1	0
Remembering appointments, family occasions, holidays, medications	3	2	1	0
Traveling out of neighborhood, driving, arranging, to take buses	3	2	1	0
TOTALS	____	____	____	____