SONI FAMILY MEDICINE

Annual Wellness Visit – for Patient

Patient Name: _____ **DOB:** _____ **Date:** _____

FAMILY HISTORY (i.e. Alcoholism, Bleeding Disorders, Cancer, CAD, Diabetes, Memory Loss, Mental Disorders)	
Father	
Mother	
Siblings	

☐ **NA** **MEDICAL & SURGICAL HISTORY**

Please ✓ : (past conditions, injuries, operations, hospitalization)

☐ Coronary Artery Disease	☐ CVA (Stroke)	☐ Heart Failure	☐ Cancer (specify)
☐ Old Myocardial Infarction	☐ Late effect CVA	☐ Hypertension	☐ Amputations (location)
☐ Peripheral vascular disease	☐ Deep Vein Thrombosis	☐ Dyslipidemia	☐ Ostomy (location) **Circle:** Active or Reversed
☐ COPD	☐ Pulmonary Embolism	☐ Osteoporosis	☐ Major Organ Transplant
☐ Chronic Kidney Disease	☐ Seizure	☐ Pathologic Compression Fx	☐ Urinary Incontinence
☐ Renal Dialysis	☐ Chronic Hep B	☐ Major Depression	
	☐ Chronic Hep C	☐ Dementia	
		☐ Diabetes	

OTHER:

__ **No Known Allergies**	**ALLERGY LIST with REACTION**

☐ **NA** **MEDICATION LIST with DOSAGE (CPT II CODES: 1159F and 1160F)**

(please include Vitamins and OTC Meds)

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

☐ All Medication Reviewed With Patient (provider must ✓ box)

☐ **NA** **SPECIALISTS & Durable Medical Equipment SUPPLIERS**

Patient Name: _____ **DOB:** _____ **Date:** _____

SOCIAL HISTORY

Living Arrangements: ☐ Alone With: ☐ Spouse ☐ Family ☐ Caregiver ☐ Assisted Living
Living Will: ☐ YES ☐ NO **DNR:** ☐ YES ☐ NO **Medical POA Designee:** _____

Occupation:	Retired ☐ Yes	Exercise type/frequency

Tobacco ☐ Current ☐ Smoke ☐ Chew Pack/Years: ☐2nd Hand ☐Never ☐Prior Use Quit Date:

Alcohol ☐ Never ☐ Occasional ☐ Daily #of drinks _____ day/ week/ month/ year

CAGE Questionnaire: ☐**1**. Have you ever felt you should **C**ut down ☐**2.** Have people **A**nnoyed you by criticizing your drinking? ☐**3.** Have you ever felt bad or **G**uilty about your drinking? ☐**4**. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye Opener)? ☐**5. NONE OF THE ABOVE**
Score of ≥ 2 considered clinically significant. Further assess for alcohol dependence.

1.	Have you had any falls in the past year? If "**yes**"; how many falls:	☐ Yes	☐ No
2.	Do you have any weaknesses of the extremities that interfere with your self-care or motility?	☐ Yes	☐ No

3. Do you feel safe in your home? ☐ Yes ☐ No

4. Have you noticed any difficulties with the following? (✓all that apply)
☐ Vision ☐ Hearing ☐ Speech ☐ Urinary: ___ Incontinence ___ High Frequency

5. Do you need any assistance with the following? (✓all that apply)
☐ Dressing ☐ Bathing ☐ Toileting ☐ Transferring ☐ Eating/Feeding

6. Do you need assistance with any of the following? (✓all that apply)
☐ Shopping ☐ Driving ☐ Using the telephone ☐ Meal preparation ☐ Housework ☐ Home repair
☐ Laundry ☐ Taking medications ☐Handling finances

PAIN SCREENING (CPTII CODES: 0521F, 1125F OR 1126F)

Do you have any pain? ☐ Yes ☐ No	If so where?

If pain is present, circle intensity (0=no pain; 10=worst pain): **0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10**

What causes or increases the pain?

DEPRESSION SCREENING - PHQ-9

Intended for: screening patients w/o diagnosis of Major Depression or to monitor treatment of Major Depression

Over the past 2 weeks, how often have you been bothered by any of the following problems?) (use "✓" to indicate your answer)	None **0**	Several Days **1**	More Than ½ the Days **2**	Nearly Every Day **3**
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people would have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts you would be better off dead, or of hurting yourself in some way				
(If you ✓ 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 (circle)	Not difficult	Somewhat difficult	Very difficult	Extremely difficult
If there are at least 5 ✓ s in the shaded section of questions 1-9 (one must be question #1 or #2) and a response in the shaded area of the last question, then consider diagnosing Major Depression			**TOTAL SCORE:**	

Patient Name: _____ DOB: _____ Date: _____

DRUG DEPENDENCE
☐NA
Dependence to: ☐Opioids ☐Benzodiazepine ☐Cannabis ☐Cocaine ☐Amphetamine ☐Other: _____
(MUST indicate at least 3 criteria: unless in remission)
☐ withdrawal symptoms ☐ longer use than intended ☐unsuccessful efforts to quit ☐excessive time spent to obtain
☐ tolerance ☐ social, occupational, recreational activities affected ☐ continuous use despite adverse consequences
Please ✓ ☐ Continuous ☐ Episodic ☐ In Remission
Please ✓ ☐ Stable ☐ Improving ☐ Worsening

COUNSELING AND REFERRAL OF PREVENTIVE SERVICES	DATE COMPLETED OR SCHEDULED
☆ **Mammogram:** Female Age 50 – 74 (MY & prior year)	☐ NA
☆ **Colorectal Cancer screening**: Age 50 – 75 (Colonoscopy every 10 years, FIT test yearly, or Sigmoidoscopy every 5 years)	☐ NA
☆ **Osteoporosis Management:** Female Age 67 – 85 (Dexa scan or treatment for osteoporosis within 6 months of a fracture)	☐ NA
☆ **Diabetic Retinopathy screening (eye exam):** (yearly or negative in the prior year)	☐ NA
☆ **Diabetic Nephropathy screening:** (yearly microalbumin or treatment with ACE/ARBs)	☐ NA
☆ **Diabetic HbA1c: every 3-6 months** (goal < 9%)	☐ NA
Abdominal Aortic Aneurysm screening: Male ≥65 with h/o 100 cig/lifetime or family h/o AAA (requires prior authorization)	☐ NA
Other Preventive Screening: (Please ☐) ☐ HIV Screening ☐ PAP/Pelvic Exam ☐ PSA Other:_	☐ NA

Vaccinations with Date:	Flu Date:	Pneumovax 23 Date: Prevnar 13 Date:	Tetanus Date:	Shingles Date:

☆ **Rheumatoid Arthritis present**	☐ Yes	☐ No	**Patient on DMARD**	☐ Yes ☐ No
☆ **Hypertension**	☐ Yes	☐ No	**Pt BP controlled:** (Ages 18-59, 60 – 85 w/DM: <140/90, Ages 60 – 85: <150/90)	☐ Yes ☐ No

I certify that the information provided on this assessment form is accurate, complete and current as of the date of exam noted on this page. I have personally examined the patient and indicated the patient's condition by noting the relevant diagnoses and supporting information. The diagnoses have been derived through: patient history, face-to-face patient examination, and completion of diagnostic studies. I understand this document will become a permanent part of the patient's medical record.

Provider Signature: _____ **M.D. D.O. N.P. P.A.** (circle one)

Provider Name: Rajesh Soni, MD

Date: _____

RECENT SYMPTOM QUESTIONNAIRE

Patient Name: _____ Date: _____

Have you had any of the following symptoms in the past two months? Write comments if you like.

GENERAL

fatigue	☐ Yes	☐ No
unexplained recurring fever	☐ Yes	☐ No
night sweats	☐ Yes	☐ No
unexplained weight gain	☐ Yes	☐ No
unexplained weight loss	☐ Yes	☐ No

EYES, EAR, NOSE & THROAT

vision problems	☐ Yes	☐ No
hearing difficulty or deafness	☐ Yes	☐ No
ringing in ears	☐ Yes	☐ No
frequent nose bleeds	☐ Yes	☐ No
nasal congestion/sinus problems	☐ Yes	☐ No
bleeding gums	☐ Yes	☐ No
chronic hoarseness	☐ Yes	☐ No
chronic sores in mouth or throat	☐ Yes	☐ No
seasonal or year long allergies	☐ Yes	☐ No

HEART (CARDIOVASCULAR)

chest pains or pressure	☐ Yes	☐ No
pains in the lower legs from walking	☐ Yes	☐ No
trouble breathing with walking	☐ Yes	☐ No
irregular heart beats	☐ Yes	☐ No
trouble breathing laying flat	☐ Yes	☐ No
lower leg swelling	☐ Yes	☐ No
racing heart	☐ Yes	☐ No

LUNGS (PULMONARY)

chronic cough	☐ Yes	☐ No
shortness of breath	☐ Yes	☐ No
coughing up blood	☐ Yes	☐ No
pain in chest with breathing	☐ Yes	☐ No
wheezing	☐ Yes	☐ No

GASTROINTESTINAL

abdominal pain	☐ Yes	☐ No
poor appetite	☐ Yes	☐ No
bloating or swelling of the abdomen	☐ Yes	☐ No
difficulty or pain with swallowing	☐ Yes	☐ No
constipation	☐ Yes	☐ No
diarrhea	☐ Yes	☐ No
indigestion or heartburn	☐ Yes	☐ No
blood in stools	☐ Yes	☐ No
chronic nausea or vomiting	☐ Yes	☐ No
stool caliber change	☐ Yes	☐ No

GENITOURINARY

pain or burning while urinating	☐ Yes	☐ No
genital lesions	☐ Yes	☐ No
blood in urine	☐ Yes	☐ No
difficulty controlling bladder	☐ Yes	☐ No
frequent nighttime urination	☐ Yes	☐ No
difficulty passing urine	☐ Yes	☐ No
sexual issues	☐ Yes	☐ No
breast lumps/changes	☐ Yes	☐ No
low sex drive	☐ Yes	☐ No

MUSCULOSKELETAL

painful joints	☐ Yes	☐ No
chronic back pain	☐ Yes	☐ No
chronic pain in arms or legs	☐ Yes	☐ No
muscle aches	☐ Yes	☐ No

SKIN

changing shape or size of moles	☐ Yes	☐ No
rash	☐ Yes	☐ No
easy bruising	☐ Yes	☐ No
easy bleeding	☐ Yes	☐ No
swollen glands	☐ Yes	☐ No

NEUROLOGIC

balance problems	☐ Yes	☐ No
dizzy spells	☐ Yes	☐ No
fainting	☐ Yes	☐ No
frequent headaches	☐ Yes	☐ No
memory loss	☐ Yes	☐ No
tremor	☐ Yes	☐ No
weakness in arms or legs	☐ Yes	☐ No

PSYCHIATRIC

anxiety	☐ Yes	☐ No
crying spells	☐ Yes	☐ No
depression	☐ Yes	☐ No
feeling stressed	☐ Yes	☐ No
loss of interest in fun activities	☐ Yes	☐ No
personality changes	☐ Yes	☐ No
poor concentration	☐ Yes	☐ No
sleeping problems	☐ Yes	☐ No
suicidal thoughts	☐ Yes	☐ No

Other _____