Anchor Internal Medicine

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Annual Wellness Form

Name: **DOB:**

☐Male ☐Female **Email Address:**

Check Preferred: ☐Cell ☐ Home

☐Married ☐Single☐Divorced ☐Widowed

Pharmacy and intersection or phone number:

Allergies and Adverse Reactions to Medications

Name of Medication or Substance	Reaction/ Side Effect

Medications and All Supplements

Name and Dosage	How many times taken per day	I Take only as needed	I Take every day	Refill needed?
		☐	☐	☐
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Any health issues or concerns to discuss today:		
Any Hospitalizations in the past year? **☐Yes ☐No**	**Date and Hospital**	**Comments**
Any surgeries in the past year? **☐Yes ☐No**	**Type and Date and Surgeon**	**Comments**
Any new medical problems? **☐Yes ☐No**	**Nature of Problem:**	**Who is treating?**
Any New health problems or deaths in your family?	**☐Yes (Comments):** **☐No**	

Mental Health

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all** **0**	**Several days** **1**	**More than half the days** **2**	**Nearly every day** **3**
Little Interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

Health Habits

1. Which of the follow describes you?
☐ Never Smoked or Used other Tobacco Product (Skip to question 2)
☐ Current Smoker: How many cigs per day? For how many years?
☐ Occasional Smoker ☐ Do you use other form of Tobacco ? Describe:
☐ Former Smoker or other Tobacco User: For how long ? Quit Date?

2. Do you drink Alcohol?	Yes ☐	No ☐	How many per day?		How many per week?	

Do you worry that you drink too much?	

Vaccinations: Only List any done since last visit

☐ Tetanus (dT)	Date	☐ Prevnar 13 or 20	Date	☐ Gardasil (HPV)	Date
☐ Tetanus with Whooping cough (Tdap)	Date	☐ Pneumovax 23	Date	☐ Flu Shot	Date
☐ Hepatitis A	Dates	☐ Shingrix X 2 (new Shingles shot)	Dates	☐ Other	Date
☐ Hepatitis B	Dates	☐ COVID	Date(s)	☐ Other	Date

Health Maintenance: List most recent

Colon Cancer Screening ☐Colonoscopy ☐Cologuard Test ☐Other	Date	Findings/When due Again	Doctor
Dilated Eye Exam	Date	If Diabetic was there any Diabetic Retinopathy found? ☐Yes ☐No	Doctor
Mammogram	Date	☐Normal ☐Abnormal	Facility
Bone Density	Date	Findings ☐Normal ☐Osteopenia ☐Osteoporosis	Doctor/ Facility
Pap/ Pelvic	Date	☐Normal ☐Abnormal	Doctor
PSA/Prostate Exam	Date	☐Normal ☐Abnormal	Doctor

Other Physicians, Please list

Name/ Specialty	Name/ Specialty

Fall Screening- (Medicare Patients Only)

Have you had any falls in the last 12 months?☐Yes☐No **Did you suffer any injury? ☐Yes☐No**	**Comments**
Do you feel you are at risk of falling? ☐Yes☐No	

Activities of Daily Living: Do you have trouble:

Keeping your balance when walking?	**☐No Issues**	**☐Need mild assistance**	**☐Always need help**
Getting out of chairs and walking without assistance?	**☐No Issues**	**☐Need mild assistance**	**☐Always need help**
Climbing Stairs?	**☐No Issues**	**☐Need mild assistance**	**☐Always need help**
Carrying out shopping, cooking, driving, managing finances?	**☐No Issues**	**☐Need mild assistance**	**☐Always need help**
Do you have a living will?	**☐Yes**	**☐No**	**☐Need Information**