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FAMILY PRACTICE PHYSICIAN

Wellness Visit Form

Name:_____

1. Current Review of Systems (circle/list symptoms you currently have)

Constitutional symptoms: fever, weight loss, weight gain, extreme fatigue

Eyes: double vision, sudden loss of vision, blurred vision

Ear, nose and throat: sore throat, congestion, runny nose, ear pain, ringing in ears

Cardiovascular: chest pain, heart racing sensation, swelling

Respiratory: cough, wheezing, shortness of breath

Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools, jaundice

Genitourinary: discharge, frequent urination, painful urination, bloody urine, impotence, poor urine stream

Skin: acne, rash, changing mole, sore or ulcer

Neurological: headache, weakness, numbness or tingling, falling, dizziness, vertigo

Musculoskeletal: joint pain, joint swelling, muscle weakness, muscle aches

Psychiatric: depression, anxiety, suicidal thoughts

Endocrine: excessive thirst, cold or heat intolerance

Hematologic: unusual bruising or bleeding, enlarged lymph nodes

Other: _____

2. Social History (please circle, fill in, and √ your responses)

__ I have never used tobacco - or - __ I used to use tobacco but quit in _____ (which year?). – or -

__ I currently use tobacco: dip / vape / smoke ___ cigarette / packs per day and have for ___ years

__ I do not drink alcohol – or - __ I drink ___ drinks every [day / week / month / socially.] Usually [beer / wine / liquor].

__ I do not use illicit drugs - or - Drugs I currently use _____.

I am [working / unemployed / retired / stay at home]. My current or previous employment: _____

I am [single / married / widowed / living with significant other]. __ I have been or was married for ___ years.

I live in a [house / apartment / mobile home] with (circle): spouse, __children, mother, father, __ siblings, ___ pets

__ I do not exercise – or - __ I do exercise __ times a week for ___ minutes. My exercise is:_____

3. Anything new in your medical or surgical history? __No __Yes (please list) _____

4. Anything new in your family history? __No __Yes (please list) _____

5. In the last 2 weeks have you felt down, depressed or hopeless? __No ___Yes

6. In the last 2 weeks have you had little interest or pleasure in doing things? __No ___Yes

7. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? ___No ____Yes

8. Does your home have rugs in a hallway, or lack grab bars in the bathroom, or lack handrails on the stairs, or have poor lighting? __No ___Yes **8b. Any Falls?** ___No ____Yes

9. Have you noticed any hearing difficulties? ___No ___ Yes

10. Do you use an opiate medication? ___No ____Yes

11 . Please inform assistant of new medications or refills needed. Thank you!

Con Adv AAA/M DEX DM Cs CT 7 18 Lip T A1 Um HCV P Pn Pr Z F