Name_____ DOB _____

Annual Wellness Questions /(COA)

Please list any specialists that you are seeing and any medical equipment providers being used:

Do you have any of the following? (*Risk Factors)

Hypertension Diabetes Current Tobacco Use High Cholesterol

Family History of Colon Cancer Family History of Breast Cancer

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During the past two weeks, have you been bothered by any of the following problems? (*PHQ2)

Little interest or pleasure in doing things:
Not at all Several Days More than half the days Nearly every day

Feeling down depressed or hopeless:
Not at all Several Days More than half the days Nearly every day

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During the past few weeks what has been your highest level of physical activity?
VERY LIGHT LIGHT MODERATE* HEAVY VERY HEAVY

Advanced Care Planning (*enter)
Do you have a:

Living Will?	YES	NO	NOT SURE
Health Surrogate?	YES	NO	NOT SURE
Do Not Resuscitate Order ?	YES	NO	NOT SURE

Do you have any problems with leakage of urine? (*bladder control) YES NO*

IF YES:
When you cough/sneeze or strain? YES NO (Stress)

You feel like you need to rush in order to avoid leakage? YES NO (Urge)

Fall Risk Assessment

Have you fallen in the last 12 months:	YES	NO*
(If yes : how many times?)		
Do you or have you been advised to use a cane or walker:	YES	NO*
Do you sometimes feel unsteady while walking:	YES	NO*
Do you steady yourself by holding on to furniture:	YES	NO*
Are you worried about falling:	YES	NO*
Do you have trouble stepping up onto a curb:	YES	NO*
Do you often have to rush to the toilet:	YES	NO*
Have you lost some feeling in your feet:	YES	NO*
Do you take medicine that makes you feel light headed:	YES	NO*
Do you take medicine to help you sleep or improve your mood:	YES	NO*
Do you often feel sad or depressed:	YES	NO*

Name_____ DOB _____

Functional Status Assessment
Circle any of the following tasks that you need help with:

Grooming	Dressing	Toilet use	Housework	**None of these***
Preparing meals	Eating	Walking	Bathing	Taking Medication

(* Assess: cognitive status / ambulatory status / sensory status)

Systemic and Comprehensive Pain Assessment:

Are you experiencing daily pain? YES NO*

If yes – Where is the pain? _____

How severe is the pain? MILD MODERATE SEVERE

Psychosocial Risk Assessment:

AUDIT-C
How often did you have a drink containing alcohol in the past year?

Never	Monthly or less
Two to four times a month	Two to three times a week
Four or more times a week	

How many drinks did you have on a typical day when you were drinking in the past year?

None, I do not drink	1 or 2
3 or 4	5 or 6
7 to 9	10 or more

How often did you have six or more drinks on one occasion in the past year?

Never	Less than monthly
Monthly	Weekly
Daily or almost daily	

Is your home free of throw rugs, poor lighting or a slippery bathtub/shower? YES* NO

Does your home have grab bars in the bathroom? YES* NO

Does your home have handrails on stairs and steps? YES* NO

Does your home have functioning smoke alarms? YES* NO

(*Add Body Mass in assessment / BMI and BP CPT codes ---- Delete one pain/Fall code --- Reconcile Medications ---- Update CC ---- Additional Present)