Einstein HEALTHCARE NETWORK

Name: _____DOB: ____/___/_____

MR: _____FIN: _____

# ANNUAL WELLNESS VISIT
# HEALTH RISK

Dear _____,

Your Appointment for the ❑Welcome to Medicare Visit ***OR*** ❑Annual Wellness Visit is scheduled

on_____ at _____.

There is **NO CO-PAY** for this visit, so it is free for you!

The goal of this visit is to provide time for you to discuss with our health care team, areas of your health that may put you at risk for problems and to help you and your provider better understand what screenings you should get in the future.

At your wellness visit, we will take a complete health history and provide several other services:

- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- A screening schedule for appropriate preventive services will be developed
- Risk factors and treatment options will be reviewed and recommended

This is **NOT** a "Problem Visit and **WILL NOT** include treatment or management of problems.

So that your provider has all necessary information, **please complete ALL of the enclosed forms and bring them with you to your visit.**

**If you arrive at the office without these forms, your visit may need to be rescheduled.**

Please make sure to be on time and call with more than 24 hours' notice if you cannot make your appointment.

We look forward to seeing you soon!

Einstein HEALTHCARE NETWORK

Name: _____DOB: ____/___/_____

MR: _____FIN: _____

# ANNUAL WELLNESS VISIT
# HEALTH RISK

_____**Patient Consented to a Telehealth Visit** **Telehealth Visit scheduled: _____**

| | | |
|---|---|---|
| **AWV PERFORMED BY:** | Name (Print): | Date: |
| | Signature: | |

**<u>Please complete the entire questionnaire as thoroughly as possible so that your provider has a complete and up to date history. This confidential history will be part of your permanent medical record.</u>**

**Please list any ADDITIONAL providers and suppliers of your medical care such as primary care physicians, specialty physicians, chiropractors, pharmacies, herbalists and therapists.**

| PROVIDER NAME | SPECIALTY |
|---|---|
| | |
| | |
| | |

**Have you changed your Pharmacy? If yes, Please add name and address below:**

_____

| MEDICATIONS |
|---|
| ******You must bring all your medications with you to this visit****** *(including anything you take over the counter)* |

| NUTRITION | |
|---|---|
| How many servings of fruits and vegetables do you have in a day | ❑None ❑1-2 ❑3-4 ❑5+ ❑I don't know |
| How many servings of meat, fish or other proteins do you have in a day? | ❑None ❑1-2 ❑3-4 ❑5+ ❑I don't know |
| How many servings of fiber or whole grains do you have in a day? | ❑None ❑1-2 ❑3-4 ❑5+ ❑I don't know |

Einstein HEALTHCARE NETWORK

Name: _____DOB: ____/___/_____

MR: _____FIN: _____

# ANNUAL WELLNESS VISIT
# HEALTH RISK

| | |
|---|---|
| How many servings of fried or high-fats foods do you have in a day? | ❑None ❑1-2 ❑3-4 ❑5+ ❑I don't know |
| How many servings of sugar sweetened drinks do you have in a day? | ❑None ❑1-2 ❑3-4 ❑5+ ❑I don't know |

**The following ADHOC Forms have been completed in the patients chart:**

| DEPRESSION SCREENING (PHQ9) Office Use Only | |
|---|---|
| _____ Completed | _____ Your Initials |

| FALL RISK SCREENING – Office Use Only | |
|---|---|
| _____ Completed | _____ Your Initials |

| GENERAL WELL-BEING | | | | | |
|---|---|---|---|---|---|
| In general, would you say your health is? | ❑Excellent | ❑Very good | ❑Good | ❑Fair | ❑Poor |
| Do you take all your medications as prescribed? | ❑Yes | ❑No | ❑Sometimes | ❑Almost Never | ❑I don't take medication |
| In the last six months, how many times were you admitted to the hospital? | ❑ 0 | ❑1-2 | ❑3-4 | ❑5+ | ❑I don't know |
| In the last six months, how many times have you been to the emergency room? | ❑ 0 | ❑1-2 | ❑3-4 | ❑5+ | ❑I don't know |

| SOCIAL/EMOTIONAL SUPPORT | | | | | |
|---|---|---|---|---|---|
| How often do you get the social and emotional support you need? | ❑Always | ❑Usually | ❑Sometimes | ❑Rarely | ❑Never |

| STRESS/ANGER | | | | |
|---|---|---|---|---|
| How often is stress/anger a problem for you? | ❑Never, rarely | ❑Sometimes | ❑Often | ❑Always |
| How well do you handle the stress/anger in your life? | ❑I'm usually able to cope effectively | ❑At times I have problems coping | ❑I often have problems coping | |

Einstein HEALTHCARE NETWORK

Name: _____DOB: ____/___/_____

MR: _____FIN: _____

# ANNUAL WELLNESS VISIT
# HEALTH RISK

| PAIN/FATIGUE | | | | |
|---|---|---|---|---|
| How often do you feel unusually tired? | ❑Never, rarely | ❑Sometimes | ❑Often | ❑Always |
| Do you have pain that interferes with performing desired activities? | ❑Never, rarely | ❑Sometimes | ❑Often | ❑Always |

| SLEEP | |
|---|---|
| How many hours of sleep do you usually get? | ❑0-3 ❑4-6 ❑7-10 ❑10+ ❑I don't know |
| Do you snore or has anyone told you that you snore? | ❑Yes ❑ No ❑ I don't know |
| In the past 7 days, how often have you felt sleepy during the daytime? | ❑Often ❑Sometimes ❑Almost never ❑Never ❑ I don't know |

| FUNCTIONAL ABILITY ASSESSMENT | |
|---|---|
| ***Instrumental activities of daily living*** | |
| Which of the following can you do on your own? | ❑Shop for groceries ❑Use the telephone ❑Housework ❑Handle finances ❑Drive/use public transportation ❑Make meals ❑Take medications ❑None |
| Which of the following can you do on without help? | ❑Bath ❑Walk ❑Dress ❑Eat ❑Transfer in/out of chair, etc ❑Use the restroom ❑None |
| **URINARY INCONTINENCE ASSESSMENT (WOMEN ONLY)** | |
| During the last three months, have you leaked urine (even a small amount)? When: | You were performing some physical activity (coughing, sneezing, lifting or exercise? ❑Yes ❑No (if NO STOP) |
| During the last 3 months did you leak urine when:<br>When:<br>(check all that apply) | ❑ You were performing some physical activity (coughing, sneezing, lifting or exercise?<br>❑ You had the urge or the feeling that you needed to empty your bladder?<br>❑ Without physical activity and without a sense of urgency? |
| During the last three months, did you leak urine most often (check only one): | ❑ When you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?<br>❑ When you had the urge or the feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?<br>❑ Without physical activity and without a sense of urgency?<br>❑About equally as often with physical activity as with a sense of urgency? |

Einstein HEALTHCARE NETWORK

Name: _____DOB: ____/___/_____

MR: _____FIN: _____

# ANNUAL WELLNESS VISIT
# HEALTH RISK

| AMBULATION STATUS | |
|---|---|
| How long can you walk or move around? | ❑0-5 ❑5-15 ❑15-30 ❑More than 1 hour ❑ I don't know |
| Do you feel unsteady when standing or walking? | ❑Yes ❑ No ❑Sometimes ❑ I don't know |
| Which of these assistive devices do you use? | ❑Cane ❑Walker ❑Wheelchair ❑Crutches ❑Other ❑None |
| Do you feel dizzy when you get up from a bed or chair? | ❑Yes ❑ No ❑Sometimes ❑ I don't know |
| Are you afraid to leave the house alone due to dizziness or imbalance problems? | ❑Yes ❑ No ❑Sometimes ❑ I don't know |

| HEARING SCREENING | |
|---|---|
| Do you have a problem with hearing? | ❑ Yes ❑ No ❑ I don't know |
| Do you use hearing aids or other devices to help you hear? | ❑ Yes ❑ No ❑ I don't know |
| Do you have a problem hearing the telephone? | ❑ Yes ❑ No ❑ I don't know |
| Do you have trouble hearing the television or radio | ❑ Yes ❑ No ❑ I don't know |
| Do people complain that you turn the TV volume up too high? | ❑ Yes ❑ No ❑ I don't know |
| Do many people you talk to seem to mumble (or not speak clearly)? | ❑ Yes ❑ No ❑ I don't know |
| Do you find yourself asking people to repeat themselves? | ❑ Yes ❑ No ❑ I don't know |
| Do you have trouble hearing in a noisy background? | ❑ Yes ❑ No ❑ I don't know |

| VISION SCREENING | |
|---|---|
| Do you have problems with your vision? | ❑ Yes ❑ No ❑ I don't know |
| Do you wear contact lenses or eyeglasses? | ❑ Yes ❑ No ❑ Sometimes |

| HOME SAFETY | |
|---|---|
| What is your living situation | ❑Alone ❑With my spouse or other family with a friend or roommate ❑ In nursing home or assisted living facility/home ❑ I don't have a place to live ❑ Other |
| Does your home have rugs in the hallways? | ❑Yes ❑No ❑ I don't know |
| Does your home have grab bars in the bathroom? | ❑Yes ❑No ❑ I don't know |
| Is there any clutter in your walking space at home? | ❑Yes ❑No ❑ I don't know |
| Does your home have functioning smoke alarms? | ❑Yes ❑No ❑ I don't know |
| Does your home have handrails on stairs and steps? | ❑Yes ❑No ❑ I don't know |

| MEMORY LOSS | |
|---|---|
| Have you experienced any memory issues or problems with thinking? | ❑Yes ❑No ❑ I don't know |
| Do family members report that you have difficulty remembering things? | ❑Yes ❑No ❑ I don't know |

Einstein HEALTHCARE NETWORK

Name: _____DOB: ____/___/_____

MR: _____FIN: _____

# ANNUAL WELLNESS VISIT
# HEALTH RISK

| SUN EXPOSURE | |
|---|---|
| Do you use Sun protection when outdoors | ❑Yes ❑No ❑ I don't know |

## ADVANCE CARE PLANNING

_____ Completed _____ Your Initials

**ADVANCED CARE PLANNING:** Your responses to the following 10 questions may help you to better understand your thoughts on quality of life when considering treatment options: Check the appropriate answer for each question.

| Consider the following statements and how important Advanced care planning is for you. | Very important | Somewhat important | Not Very important |
|---|---|---|---|
| 1. Be free of pain<br>*Comments:* | | | |
| 2. Able to physically care for myself<br>*Comments:* | | | |
| 3. Live at Home<br>*Comments:* | | | |
| 4. Able to be outside and not spend all day at home<br>*Comments:* | | | |
| 5. Able to talk and understand others<br>*Comments:* | | | |
| 6. Die naturally and not be keep alive by machines<br>*Comments:* | | | |
| 7. Be financially independent<br>*Comments:* | | | |
| 8. Ability to do the activities I most enjoy.<br>*List of Activities:* | | | |
| 9. Do you have an Advance Directive, Living Will or Power of Attorney for Health Care (POA), in the case that an injury or illness causes you to be unable to make healthcare decisions? | ❑Yes ❑No ❑ I don't know | | |
| 10. Would you like further information regarding Advance Directives? | ❑Yes ❑No ❑ I already have one | | |

*****IF YOU HAVE AN ADVANCED DIRECTIVE OR LIVING WILL, PLEASE BRING A COPY OF YOUR ADVANCED DIRECTIVE WITH YOU TO YOUR VISIT**

Einstein HEALTHCARE NETWORK

Name: _____DOB: ____/___/_____

MR: _____FIN: _____

# ANNUAL WELLNESS VISIT
# HEALTH RISK

| PHYSICAL ACTIVITY | |
|---|---|
| Number of days patient exercises | _____ days |
| Number of minutes patient exercises | _____ minutes |
| Intensity of exercise | ❑Mild ❑Moderate ❑ |

| MOTOR VEHICLE SAFETY | |
|---|---|
| Use of seatbelt while in the car | ❑ Always ❑Occasionally ❑Never |
| Drinking and driving | ❑ Occasionally ❑ Never |

| OFFICIAL USE ONLY | | |
|---|---|---|
| **HRA Reviewed by:** | Clinician Name (Print) | Date: |
| | Clinician Signature: | |

Einstein HEALTHCARE NETWORK

Name: _____DOB: ____/___/_____

MR: _____FIN: _____

# ANNUAL WELLNESS VISIT
# HEALTH RISK

## WellRx Questionnaire

**_____ Completed** **_____ Your Initials**

**Your medical team at Einstein Healthcare:** recognizes that there are many things in life that affect your health. Sometimes that means talking about things that aren't "medical," but are things that are making you feel stressed or concerned about.
Below you will find questions about some common needs and concerns often faced by patients and families. This is **voluntary** and you can skip any questions you do not wish to answer.

| | | |
|---|---|---|
| 1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food? | **NO** | **YES** |
| 2. Are you homeless or worried that you might be in the future? | **NO** | **YES** |
| 3. Do you have trouble paying for your utilities (gas, electricity, phone)? | **NO** | **YES** |
| 4. Do you have trouble finding or paying for a ride? | **NO** | **YES** |
| 5. Do you need daycare, or better daycare, for your kids? | **NO** | **YES** |
| 6. Are you unemployed or without regular income? | **NO** | **YES** |
| 7. Do you need help finding a better job? | **NO** | **YES** |
| 8. Do you need help getting more education? | **NO** | **YES** |
| 9. Are you concerned about someone in your home using drugs or alcohol? | **NO** | **YES** |
| 10. Do you need help with legal issues? | **NO** | **YES** |
| 11. Do you feel unsafe in your daily life? | **NO** | **YES** |
| 12. Is anyone in your home threatening or abusing you? | **NO** | **YES** |
| 13. In the last 6 months, have you been at the Emergency Department more than 2x?<br>If yes, how many times? _____ | **NO** | **YES** |
| 14. In the last 6 months, have you been hospitalized?<br>If yes, how many times? _____ | **NO** | **YES** |
| 15. Would you like to speak with someone about any of the questions you answered YES to? This person may be able to connect you to resources to help. | **NO** | **YES** |
| 16. If you would like to find resources on your own, you can go to https://communityresourceconnects.org | **NO** | **YES** |