ANNUAL WELLNESS VISIT QUESTIONAIRE

NAME_____ D.O.B._____/_____/_____

TODAY'S DATE _____/_____/_____

SPECIALITY PROVIDERS: List all physicians you are currently seeing or known to

ALLERGY_____ ONCOLOGY (CANCER) _____

CARDIOLOGIST (HEART)_____ OPTHALMOLOGY (EYE) _____

DERMATOLOGY (SKIN)_____ PHYSICAL THERAPY _____

GASTROENTEROLOGY (STOMACH/ LIVER) _____

PODIATRY (FOOT) _____ PAIN _____

ENT (HEAD, NECK, EAR) _____ PULMONOLOGY (LUNGS) _____

ENDOCRINOLOGY (DIABETES, THYROID) _____

NEPHROLOGY (KIDNEY) _____ RHEUMATOLOGY _____

NEUROLOGY _____ UROLOGY (BLADDER)_____

OB/GYN _____ OTHER _____

HOSPITAL STAYS: LIST ANY OVERNIGHT HOSPITALS STAYS IN THE PAST YEAR

DATE	**REASON**	**LOCATION**
1.		
2.		
3.		
4.		
5.		
6.		

ALLERGIES: LIST ANY NEW ALLERGIES TO MEDS, MEDICAL SUPPLIES, AND/OR FOOD IN THE PAST YEAR

ALLERGY	REACTION
1.	
2.	
3.	
4.	
5.	
6.	

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ANNUAL WELLNESS VISIT QUESTIONAIRE

***NAME*_____ *D.O.B.*_____/_____/_____**

MEDICATIONS: LIST ALL CURRENT PRESCRIPTIONS, OVER-THE-COUNTER MEDS, AND SUPPLEMENTS

NAME STRENGTH DIRECTION PRESCRIBED BY

1._____

2. _____

3._____

4._____

5._____

6. _____

7._____

8._____

Do you need help taking your medications? ☐ Yes ☐ No

Reminder- It is your responsibility to notify your doctor of all the prescriptions, over-the-counter medications, and supplements that you are taking during each visit. Nonadherence or noncompliance with treatment plans can often increase the exacerbation of disease or risk of death for patients with certain medical conditions like diabetes, hypertension, and heart disease amongst others.

FUNCTIONAL SCREENINGS

1. Do you need help preparing your meals or feeding yourself? ☐Yes ☐No
2. Do you need help getting to the toilet, bathing, or showering? ☐Yes ☐No
3. Do you need help getting dressed? ☐Yes ☐No
4. Do you need help getting from the bed to a chair or climbing stairs? ☐Yes ☐No
5. Do you need help walking across a room? ☐Yes ☐No
6. Do you use a cane, walker or wheelchair? ☐Yes ☐No
7. Do you need help using the telephone? ☐Yes ☐No
8. Do you need help shopping or managing your money? ☐Yes ☐No
9. Do you need help with transportation? ☐Yes ☐N
10. Have you fallen in the past year? ☐Yes ☐N If yes, were you injured? ☐Yes ☐N
11. Have you had any issues with urinary and/or bowel incontinence? ☐Yes ☐N If yes, are you on medications or have you had treatment? ☐Yes ☐N Type_____

HOME SAFETY SCREENING

1. Who lives in the home with you? _____
2. Do you have pets? ☐Yes ☐No
3. Do you have access to a phone at home? ☐Yes ☐No
4. Do you need help using the phone? ☐Yes ☐No
5. Are emergency numbers easily accessible? ☐Yes ☐No
6. Do you have functioning smoke/carbon monoxide alarms in your home? ☐Yes ☐No
7. Do you have non-slip surface and grab bars in the bath/shower? ☐Yes ☐No

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NAME_____ D.O.B._____/_____/_____

MEMORY

IN THE LAST MONTH, HOW OFTEN DO YOU HAVE TROUBLE CONCENTRATING OR FOCUSING ON TASKS?
☐ NEVER ☐ SOMETIMES ☐ USUALLY ☐ ALWAYS

IN THE LAST MONTH, HOW OFTEN DID YOU HAVE TROUBLE REMEMBERING OR THINKING CLEARLY?
☐ NEVER ☐ SOMETIMES ☐ USUALLY ☐ ALWAYS

EXERCISE

HOW MANY DAYS A WEEK DO YOU EXERCISE? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
DURATION: ☐ 30 MIN EACH TIME ☐ < 30 MIN EACH TIME ☐ > 30 MIN EACH TIME

NUTRITRION

NUMBER OF SERVINGS OF FRUITS DO YOU HAVE A DAY?
☐ 1-3 ☐ 4-7 ☐ 8-10 ☐ >10 ☐ I DO NOT EAT FRUIT

NUMBER OF SERVINGS OF VEGETABLES DO YOU HAVE A DAY?
☐ 1-3 ☐ 4-7 ☐ 8-10 ☐ >10 ☐ I DO NOT EAT VEGETABLES

DO EAT A LOW SODIUM DIET? ☐ YES ☐ NO
DO EAT A LOW-FAT DIET? ☐ YES ☐ NO
DO YOU EAT A LOW CARB DIET? ☐ YES ☐ NO

PAIN SCREENING

1. DO YOU HAVE PAIN? ☐ YES ☐ NO
2. IF YES, IS YOUR PAIN DAILY? ☐ YES ☐ NO
3. ON A SCALE OF 0 TO 10 (10 BEING THE WORST PAIN) WHAT IS CURRENT LEVEL OF PAIN? ____/10
4. DOES YOUR PAIN LIMIT YOUR DAILY ACTIVITY? ☐ YES ☐ NO
5. HOW ARE YOU TREATING YOUR PAIN? ☐ OPIOIDS ☐IBUPROFEN/NAPROXEN ☐ TYLENEOL ☐ EXERCISE
   ☐ STRETCHES ☐ COLD/WARM PACKS ☐ MASSAGE ☐ CHIROPRACTOR ☐ TENS UNIT
   ☐ OTHER (PLEASE SPECIFY) _____
6. WHICH PROVIDER(S)NARE MANAGING YOUR PAIN? ☐ PAIN MANAGEMENT ☐ ORTHOPEDICS ☐ PCP
   ☐ OTHER (PLEASE SPECIFY) _____

IMMUNIZATIONS

	LAST DOSE	REACTIONS	NEXT DOSE DUE
COVID			
FLU			
HEPATITIS B			
HPV			

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***NAME*_____ *D.O.B.*_____/_____/_____**

IMMUNIZATIONS (CONTINUED)

	LAST DOSE	REACTIONS	NEXT DOSE DUE
PNEUMONIA			
SHINGLES			
TETANUS			
RSV			

DEPRESSION SCREENING (PHQ-9): OVER THE PAST TWO WEEKS HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?				
CIRCLE YOUR ANSWER TO EACH QUESTION	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
LITTLE INTEREST OR PLEASURE IN DOING THINGS	0	1	2	3
FEELING, DOWN, DEPRESSED, OR HOPELESS	0	1	2	3
TROUBLE FALLING ASLEEP, STAYING ASLEEP, OR SLEEPING TO MUCH	0	1	2	3
FEELING TIRED OR HAVING LITTLE ENERGY	0	1	2	3
POOR APPETITE OR OVEREATING	0	1	2	3
FEELING BAD ABOUT YOURSELF OR LIKE YOU'RE A FAILURE OR HAVE LET YOURSELF OR YOUR FAMILY DOWN	0	1	2	3
TROUBLE CONCENTRATING ON THINGS SUCH AS READING THE NEWSPAPER OR WATCHING TV	0	1	2	3
MOVING OR SPEAKING SO SLOWLY THAT OTHER PEOPLE COULD HAVE NOTICED? OR OPPOSITE—BEING FIDGETYOR RESTLESS THAT YOU HAVE BEEN MOVING AROUND A LOT MORE THAN USUAL	0	1	2	3
THOUGHTS THAT YOU WOULD BE BETTER OFF DEAD OR OF HURTING YOURSELF IN SOME WAY	0	1	2	3

SCORING _____ + _____ + _____ +_____

= TOTAL SCORE _____

IF YOU CHECKED OFF 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?

NOT DIFFICULT AT ALL	SOMEWHAT DIFFICULT	VERY DIFFICULT	EXTREMELY DIFFICULT
☐	☐	☐	☐

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TOBACCO SCREENING
ARE YOU A? ☐ NEVER A SMOKER ☐ FORMER SMOKER ☐ CURRENT DAILY SMOKER ☐ CURRENT SOMEDAY SMOKER ☐ CHEWING TOBACCO USER ☐ E- CIG USER ☐ VAPOR USER
IF A *FORMER SMOKER*, HOW LONG HAS IT BEEN SINCE YOU LAST SMOKED? ☐ < 1 MONTH ☐ 1-6 MONTHS ☐ 6-12 MONTHS ☐ 1-5 YEARS ☐ 5-10 YEARS ☐ 10-15 YEARS ☐>15 YEARS
IF A *CURRENT OR FORMER SMOKER*, WHEN WAS YOUR LAST LUNG CANCER SCREENING? (Adults ages **50 to 80 years** who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.) _____/_____/_____
HOW OLD WERE YOU WHEN YOU STARTING SMOKING?
IF *CURRENT DAILY SMOKER*, HOW MANY CIGARETTES DO YOU SMOKE PER DAY? ☐ 5 OR LESS ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 OR MORE
IF *CURRENT DAILY SMOKER*, ARE YOU INTERESTED IN QUITTING? ☐ READY TO QUIT ☐ THINKING ABOUT QUITTING ☐ NOT READY TO QUIT

PREVENTION SCREENINGS- PLEASE LIST THE DATE OF YOUR LAST SCREENING

AAA (ABDOMINAL AORTIC ANEURYSM) SCREENING (SMOKERS, CURRENT AND FORMER- AGES 65-75 OR

FAMILY HX AAA) _____

COLONOSCOPY/COLOGAURD (AGE 45-75) _____

DENTAL EXAM_____ EYE EXAM _____

DEXA/BONE DENSITY (AGE 50-75) _____

EKG_____

HGB A1C (ANY PREDIABETIC OR DIABETIC) _____URINE MICROALBUMIN_____

HEARING EXAM_____LABS_____

LUNG CANCER SCREENING (SMOKING HX IN THE PAST 15 YRS AGES 50-80) _____

MAMMOGRAM (FEMALE AGES 40+) _____
PAP SMEAR/ PELVIC EXAM (FEMALES AGES 21-65) _____

PROSTATE EXAM _____ PSA _____

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NAME_____ D.O.B._____/_____/_____

ADVANCE CARE DIRECTIVES

DO YOU WISH TO DISCUSS YOUR END-OF-LIFE MEDICAL TREATMENT DECISIONS AND OR/ WHO YOU DESIGNATE TO MAKE DECISIONS FOR YOU IF YOU ARE UNABLE TO SPEAK FOR YOURSELF? ☐ YES ☐ NO

DO YOU HAVE A LIVING WILL? ☐ YES ☐ NO

DO YOU HAVE A DURABLE MEDICAL (HEALTHCARE) POWER OF ATTORNEY? ☐ YES ☐ NO

IF YES, WHO IS IT? _____

IF YOU HAVE A LIVING WILL OR DMPOA, PLEASE PROVIDE COPIES FOR YOUR CHART AS SOON AS POSSIBLE

Staff use- ADVANCED DIRECTIVE FORMS PROVIDED FOR THE PATIENT ☐ YES ☐ NO
DOCUMENTATION REVIEWED AND COMPLETED ☐ YES ☐ NO

INSURANCE REQUESTED DEMOGRAPHIC INFORMATION

1. MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ CHOOSE NOT TO DISCLOSE
2. SEX: ☐ MALE ☐ FEMALE ☐ OTHER: _____ ☐ UNKNOWN ☐ CHOOSE NOT TO DISCLOSE
3. GENDER IDENTITY: ☐ MALE ☐ FEMALE ☐ FEMALE TO MALE (FTM)/TRANSGENDER MALE/TRANS MAN
   ☐ MALE TO FEMALE (MTF)/TRANSGENDER FEMALE/TRANS WOMAN ☐ GENDERQUEER/NON-BINARY
   ☐ ADDITIONAL GENDER CATEGORY OR OTHER, PLEASE SPECIFY: _____
   ☐ CHOOSE NOT TO DISCLOSE ☐ UNKNOWN
4. SEXUAL ORIENTATION: ☐ STRAIGHT OR HETEROSEXUAL ☐ LESBIAN, GAY OR HOMOSEXUAL ☐ BISEXUAL
   ☐ SOMETHING ELSE, PLEASE SPECIFY: _____ ☐ DON'T KNOW
   ☐ CHOOSE NOT TO DISCLOSE ☐ UNKNOWN
5. OCCUPATION: _____ ☐ CHOOSE NOT TO DISCLOSE
6. YEARLY INCOME: _____ ☐ CHOOSE NOT TO DISCLOSE
7. RACE: _____ ☐ CHOOSE NOT TO DISCLOSE
8. RELIGION: _____ ☐ CHOOSE NOT TO DISCLOSE
9. LANGUAGE: _____☐ CHOOSE NOT TO DISCLOSE
10. NATIONALITY: _____☐ CHOOSE NOT TO DISCLOSE
11. COUNTRY OF ORIGIN: _____ ☐ CHOOSE NOT TO DISCLOSE
12. HIGHEST LEVEL OF EDUCATION: _____ ☐ CHOOSE NOT TO DISCLOSE
13. CHECK ALL THAT APPLY: ☐ MIGRANT ☐ HOMELESS ☐ VETERAN ☐ CHOOSE NOT TO DISCLOSE

STAFF USE ONLY
Orders given to patient for testing and screenings ☐ **YES** ☐ **NO**
Follow-up appointments needed in this office for: _____
REVIEWED WITH: _____DATE_____/_____/_____

ANNUAL WELLNESS VISIT QUESTIONAIRE

NAME_____ **D.O.B.**_____/_____/_____

Erica L. O'Donnell D.O., P.A.
Erica O'Donnell D.O. & Jessica Hills ARNP
1400 Hand Ave Suite K
Ormond Beach, FL 32174
Telephone: (386) 671-2771 Fax: (386) 671-6458

Authorization for Discussion of Medical Records

Patient Name: _____

I have been made aware of the policy and procedures of Erica O'Donnell D.O., P.A. as they relate to HIPAA Requirements.

___Yes ___No I authorize medical information to be left on the answering machine at the

phone number provided by me. Phone: _____

___Yes ___No I authorize Erica O'Donnell D.O., P.A. to discuss my medical history with the following

individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Emergency Contact Information

Emergency Contact: _____

Relationship: _____

Home Phone: _____ Cell Phone: _____

Address: ___ Same as Patient _____

City: _____ State: _____ Zip: _____

Patient Signature: _____ Date: _____

This authorization shall remain in effect for one year from the date signed above or until:
□_____ (*Specify Date; **not to exceed one year***); unless revoked in writing prior to specified dates.

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***NAME*_____ *D.O.B.*_____/_____/_____**

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PERSONAL INFORMATION CHANGE FORM

NAME CHANGE: _____

ADDRESS CHANGE: _____

PHONE # CHANGE: (____) _____

INSURANCE CHANGE: _____

EMAIL CHANGE: _____

SIGNATURE: _____ DATE: _____

ANNUAL WELLNESS VISIT QUESTIONAIRE

NAME_____ D.O.B._____/_____/_____

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Frequency of Visits

All patients of the office will be seen minimally twice a year, unless otherwise dictated by the physician, to ensure that all preventative care is performed, and any preventative testing is ordered. Any person with the following diagnoses (but not limited to these diagnoses) will be seen more frequently as outlined below:

1. Patients with hypertension (high blood pressure), hyperlipidemia (high cholesterol), prediabetes, and/or hyper/hypothyroidism (thyroid disease) will be seen minimally every 6 months.

2. Patients with diabetes, patients requiring schedule 3-5 controlled medications (at the discretion of the physician), and/or patients with an extensive problem list consisting of multiple comorbidities will be seen minimally every 3 months.

3. Patients with chronic pain and/or those patients requiring schedule 2 controlled medications will be seen every month.

4. Patients being prescribed weight loss medications will be seen at least every 3 months.

5. Any patients needing any type of forms/paperwork filled out, i.e., disability, FMLA, etc. will require an appointment to complete said forms/paperwork.

_____ __/__/__
Print Name DOB

_____ _____
Patient/Legal Guardian Signature Date

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