Optimum Internal Medicine & Pediatrics
Dr. Christopher Burress
Board certified Internal Medicine and Pediatrics

Annual Wellness Visit Patient Intake

Patient name: _____ Visit date: _____

Birthdate: _____ Record number (office use): _____

Address: _____

Please complete before your annual wellness visit. Circle or check your answers. Ask us for help with any question.

1 General health and pain

In general, would you say your health is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

How much bodily pain have you had during the past 4 weeks?

☐ None ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Are you currently having pain that affects your daily life? ☐ Yes ☐ No

If yes, rate your pain from 0 to 10: _____

0 = No pain 10 = Worst pain imaginable

2 Activities of daily living

For each activity, circle one answer.

I = Independent (can do by myself) A = Need help from another person

D = Dependent (cannot do this activity)

Walking	I A D	Using the telephone	I A D
Dressing	I A D	Shopping	I A D
Bathing	I A D	Preparing meals	I A D
Eating	I A D	Housework	I A D
Toileting	I A D	Taking medications	I A D
Driving	I A D	Managing finances	I A D
Transferring (bed or chair)	I A D		

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3 Health review

Do you have difficulty driving, watching TV, or reading because of poor eyesight? ☐ Yes ☐ No

Can you hear normal conversational speech? ☐ Yes ☐ No

Do you use hearing aids? ☐ Yes ☐ No

Do you have problems with your memory? ☐ Yes ☐ No

Do you or your family have concerns about your memory or thinking ability? ☐ Yes ☐ No

Do you often forget appointments or conversations? ☐ Yes ☐ No

Have you unintentionally lost weight in the past 6 months? ☐ Yes ☐ No

Do you have trouble controlling your bladder? ☐ Yes ☐ No

Do you have trouble controlling your bowels? ☐ Yes ☐ No

Have you had any falls in the past year? ☐ Yes ☐ No

If yes, how many falls? _____

Do you feel unsteady when walking? ☐ Yes ☐ No

Mood and anxiety

Do you often feel sad or depressed? ☐ Yes ☐ No

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?
☐ Not at all ☐ Several days

☐ More than half the days ☐ Nearly every day

Over the past 2 weeks, how often have you felt nervous, anxious, or on edge?
☐ Not at all ☐ Several days

☐ More than half the days ☐ Nearly every day

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4 Living situation and support

Do you live with anyone? ☐ Yes ☐ No

If yes, who? Check all that apply.
☐ Spouse ☐ Child ☐ Other relative ☐ Friend ☐ Other

Who would help you in an emergency? _____

Who would help with health care decisions if you could not communicate your wishes?
Name and relationship: _____

Do you have concerns about:

Affording food? ☐ Yes ☐ No

Having stable housing? ☐ Yes ☐ No

Transportation to medical appointments? ☐ Yes ☐ No

Feeling lonely or isolated? ☐ Yes ☐ No

Advance care planning

Do you have a medical power of attorney? ☐ Yes ☐ No

Do you have a do-not-resuscitate (DNR) order? ☐ Yes ☐ No

Do you have advance care planning forms to complete? ☐ Yes ☐ No

5 Medicines

How many medicines do you take, including prescriptions, over-the-counter medicines, and vitamins?
Number: _____

What system do you use for taking your medicines? Check all that apply.
☐ Pill box ☐ Family help ☐ List or chart ☐ None

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6 Personal health and habits

Are you sexually active? ☐ Yes ☐ No

Do you smoke or vape? ☐ Yes ☐ No

If yes, number of years: _____ Cigarette packs/day: _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, type: _____ Drinks per week: _____

☐ Daily ☐ Socially ☐ Occasionally ☐ Frequently

7 Personal safety

Has anyone intentionally tried to harm you? ☐ Yes ☐ No

8 Prevention

Have you had a shot to prevent pneumonia? ☐ Yes ☐ No

9 Clock drawing and memory

Complete this section with clinic staff.

Please draw the face of a clock with all the numbers and the hands to show 10 minutes after 11 o'clock.

Staff use: Three-item recall after 1 minute

Words used: pen, dog, watch Number recalled: _____ / 3

Patient signature: _____ Date: _____

Reviewing physician signature: _____ Date: _____