



Annual Wellness Exam Questionnaire

Patient Name: _____ DOB: _____ Date: _____

Patient or Guardian Signature _____

How is your health in general? (circle) **Poor Fair Good Very good Excellent**

Please list any **over-the-counter medications or supplements** that you take on a regular basis

_____ 1160F

Medical/Surgical/Family History: Any change in the past year? () Yes () No _____

How many times a week are you getting **physical activity**? _____ What kind? _____

Chronic pain: Rate your level of pain for the last 4 weeks: (Circle one) w/ pain 1125 no pain 1126F

0 1 2 3 4 5
No pain occasional very mild mild moderate severe

Yes No Do you strain to hear/understand conversations/ the TV/ the telephone?

Yes No Any difficulty walking or standing? 0518F

Yes No Any falls in the past 6 months?

Yes No Any trouble with leakage of urine? 1125F

Yes No Did you lose or gain more than 5 pounds in the last month?

Yes No Do you need help with your activities of daily livings? (check if applies) 1170F
() shopping () cooking () eating () bathing () dressing () toileting

Yes No Do you require assistance remembering appointments, family occasions, holidays or taking medications?
Compared to a few years ago, are you having more trouble with: (check if applies) 3755F
() managing money () paying bills () remembering things that happened recently
() recalling conversations after a few days

Yes No Do you currently smoke or have smoked tobacco products?
If yes how many: cigarettes/cigars daily _____ Years smoking _____ Year you quit _____

Yes No Do you drink alcohol? How many alcoholic beverages? _____ per day/week/month 3725F

Yes No Do you drive? Do you wear seatbelts in the car? **Yes No**

Yes No Do you have social and emotional support?

Yes No Do you have an Advanced Directive or Living will? 1158F

Yes No Do you have a Durable Power of Attorney? Name: _____ Ph: _____

Check if your home has: () Working smoke detectors () Carbon Monoxide detectors () Firearms
() throw rugs () non-slip bath mats () stairs () handrails

Please list any other doctors currently caring for you. List any medical supplies/equipment & vendors



Patient Name: _____ Date of Birth: _____ Date: _____
Your PCP: _____

To answer the questions below, please: Circle **0** if **not at all**
Circle **1** if **Several Days**
Circle **2** if **More than half the Days**
Circle **3** if **Nearly Every Day**

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things?.....0 1 2 3

2. Feeling Down, Depressed or hopeless?.....0 1 2 3

If you answered "Not at all" to both questions above, you may STOP HERE

3. Trouble falling or staying asleep or sleeping too much?.....0 1 2 3

4. Feeling tired or having little energy?.....0 1 2 3

5. Poor appetite or overeating?.....0 1 2 3

6. Feeling bad about yourself—or that you are a failure
or have let yourself or your family down?.....0 1 2 3

7. Trouble concentrating on things, such as reading the
newspaper or watching television, emailing.....0 1 2 3

8. Moving or speaking so slowly that other people could
have noticed? Or the opposite—being so fidgety
Or restless that you have been moving around a
lot more than usual?.....0 1 2 3

9. Thought that you would be better off dead
Or thought of hurting yourself in some way?.....0 1 2 3

10. If you are experiencing any of the problems on this form, 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?

Check the line that applies: _____ Not difficult at all (0) _____ Very Difficult (2)
_____ Somewhat difficult (1) _____ Extremely Difficult (3)

11. Please check the statement which best describes your condition:

_____ I have had difficulty with these problems for **two years** or more.

_____ I have **NOT** had difficulty with these problems for **two years** or more.

If you have had or ever do have thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your doctor or counselor, go to a hospital emergency room, or call 911.

Signature: _____ Date: _____



Office Visit vs Physical, or Both:

Irvine Family Care bills your insurance (if applicable) based upon the details of your visit. Medical necessity determines our services and coding. Please find the definitions of the visits below.

Office Visit: This is a problem-based visit to discuss new or existing medical issues. The exam and questions will focus on the reasons for the visit. This could also be a visit to follow up on chronic problems (diabetes, cholesterol, blood pressure, etc.) During the visit, your healthcare provider may prescribe medications, order lab tests, perform in-office procedures, and/or make referrals to specialists.

Annual Physical: This visit is preventative when the patient is asymptomatic and comes in with no complaints but wants a complete examination. It is a thorough review of your general well-being. The doctor will review your medical problems, perform a physical examination, and make recommendations concerning your health. This may include recommendations regarding diet and exercise, age-appropriate immunizations, and age appropriate cancer screenings.

Ongoing chronic medical problems and medication refills can be addressed as long as the condition is stable and does not require a change in treatment or additional tests.

Office Visit and Physical (Both): This is when a physical exam and office visit take place during the same appointment. For example, if you presented today for a physical and you have an acute or chronic issue that you would like addressed, it is considered a combination visit and must be billed differently than just a physical or office visit.

Difference in Billing Process: The combination visit is billed differently to account for the additional work (additional lab tests, imaging orders, referrals, or prescriptions) and expertise. It involves additional documentation as well. Since additional services are provided, you would be charged more than just for the routine annual physical.

How this Could Affect Me: Many insurance companies acknowledge the office visit/physical combination. Some of them still require the patient to pay a copay or have additional costs applied to their deductible or coinsurance. Physicals target preventative care and are billed as such. Medication refills and/or other ailments, injuries, or illnesses addressed during the physical are billed in addition to the physical. These charges may be passed on to the patient. Please check with your insurance company to confirm your coverage for all types of doctor visits. We realize this can be confusing. If you have any questions or concerns after reviewing this material, please ask.

Patient signature _____ Date _____

Printed name _____ DOB _____