Newport Beach Medical Associates  
361 Hospital Road, Ste. 322  
Newport Beach, CA  92663  
949 – 574 - 0777  

Annual Wellness Visit Questionnaire

Patient Name: __________________________ Date: __________________________

Patient or Guardian Signature _____________________________________________

Print name of Guardian ___________________________________________________

Patient Date of Birth __________________________ Patient Age _____________ Male / Female

Please provide a list of all other physicians you currently see or have seen this year:

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<th>Name</th>
<th>Specialty</th>
<th>Reason</th>
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Please provide a list of all vendors you obtain medical supplies from:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please provide a list of all medications you currently take including over the counter supplements:

________________________________________________________________________ Dose ______________ Frequency ____________

________________________________________________________________________ Dose ______________ Frequency ____________

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________________________________________________________________________ Dose ______________ Frequency ____________
Overall Health Assessment: Any changes from last year?  
Yes  No

If YES list ________________________________

**Hearing**
Do you have trouble hearing the TV or telephone when others do not?  
Yes  No
Do you have to strain to hear/understand conversations?  
Yes  No

**Home Safety**
Does your home have “throw” rugs?  
Yes  No
Do you use a non-slip bath mat in the tub or shower?  
Yes  No
Do you have handrails on all steps and stairs?  
Yes  No
Does your home have working smoke detectors?  
Yes  No

**Balance**
Have you had a fall in the last year or feel unsteady on your feet?  
Yes  No

**Daily Routine**
Do you live alone?  
Yes  No
Do you need help with any of the following? (Please circle all that apply)

- Preparing meals
- Shopping
- Driving/transportation
- Bathing
- Walking distances
- Managing your finances

Do you get enough physical activity?  
Yes  No

**Cognitive Health**
Do you have any concerns about your memory or other cognitive functions?  
Yes  No

Please circle any of these tasks that you are having difficulty with:

- Remembering to take medication
- Recalling past events
- Recalling names
- Word retrieval
- Recalling historic events or dates
- Getting lost while driving
- Remembering appointments
- Completing Complex tasks (preparing taxes, planning projects, balancing the checkbook)

Compared to 10 years ago, my memory is: (circle response)

- A lot worse
- A little better
- A little worse
- A lot better
- About the same (no change)
- Not Certain
**How are you feeling?**

During the past 4 weeks, have you been bothered by emotional problems, such as feeling anxious, depressed, irritable, sad or downhearted and blue?  
Yes  No

Have you lost interest in activities you usually enjoy?  
Yes  No

Have you had a loss or increase in your appetite?  
Yes  No

Have you had any problems with insomnia or sleeping excessively?  
Yes  No

Pain – Do you have any pain?  
Where?  
Yes  No

**Are you a smoker?**
Yes  No  Yes, but I’m ready to quit

**During the PAST 4 WEEKS, how many drinks of wine, beer or other alcoholic beverages did you have?**
None  1 drink or less per week  2-5 per week
6-9 per week  10 or more per week

**Patient Name:**  
Date:

**Vision Assessment**

Have you seen an optometrist or ophthalmologist in the last year?  
Yes  No

If not, we will have one of our staff check your vision today:

**Uncorrected**  **Corrected**

Right Eye (OD)
Left Eye (OS)
Both eyes (OU)

**Health Screening Exams**

Please list the date and findings of your most recent:

Colonoscopy

PSA and Rectal exam (males)

Mammogram (females)

Bone Density test (DEXA)
Vaccines

Please list the date you last received this vaccine:

Tetanus: Td (Tetanus/Diptheria) or Tdap (Tetanus/Diptheria/Pertussis) ____________________________

Pneumovax: pneumonia vaccine ____________________________

Zostavax: Shingles vaccine ____________________________

Influenza: flu shot ____________________________

Do you have an Advanced Directive? YES _____ NO _____

Patient Name: ___________________________________________ Date: ______________________

Physician Signature: ______________________________________ Date: ______________________