ANNUAL WELLNESS FORMS - COVERPAGE

We look forward to your upcoming Annual Wellness Visit (AWV) at Desai Medical Center

Please complete and submit the Annual Wellness Forms before your visit.

This will help expedite your appointment and reduce physical interactions at the office.

If you do not submit your forms before your visit, we may have to reschedule your appointment.

PDF PAGE #	FORM TYPE	NOTES/INSTRUCTIONS Do not leave any blank responses – put "None" or "N/A"
1	Coverpage	• Outline and instructions for Annual Wellness Forms
2	COVID-19 Checklist	• Answer "Yes" or "No"
3 & 4	Annual Wellness Exam Assessment	• Answer Multiple Choice Questions

5	Preventive Care Recommendations	• Write your responses under the **Previous** column
		  ○ If you do not remember the exact date, put month/ year
		• Write your responses under the **Family History** sections
		  ○ Identify family member to cancer/condition

6	Physical Questionnaire	• Write your responses under the **Patient's Response** column
7	Physical Questionnaire - Diagram	• Checkmark what applies to you • Mark the diagram to indicate any problem areas
8	Patient Care Team	• Provide information about the other doctors you see • If you see a physician whose specialty is not listed, please provide their information

Forms should be filled out electronically

- Use *Adobe Reader*
  - Open the PDF in Adobe Reader
  - Go to *Tools*
  - Select *Fill & Sign*
- After you complete your forms, make sure to add your name (LAST, First) in the file name when you *Save*

If you do not have Adobe Reader, download it for free, https://acrobat.adobe.com/us/en/acrobat/pdf-reader.html

Forms should be submitted electronically

- Use *MedTunnel*
  - Log in to MedTunnel with your ID and PW
  - Click *Compose Message*
  - In the *To* field – Enter our MedTunnel ID, DesaiMedicalCenter
    - If it says "No matches found" – ignore it
  - In the *Message* field – Type any message you want to send
  - In the *Attachments* section – Drag and drop the files you want to send
  - Click *Send*

If you do not have a MedTunnel ID, sign up for free, https://server.medtunnel.com/SignUp.aspx#form1

COVID-19 Checklist

Last Name:_____ **First Name:**_____ **DOB:**_____ **Date:**_____

Write "Yes" or "No" in the appropriate column	YES	NO
1. Are you exposed to anyone with a confirmed diagnosis of COVID-19?		
2. Are you exposed to anyone who may have an unconfirmed diagnosis of COVID-19?		
3. Have you attended any gatherings or parties in the last 14-21 days where there is a group of people?		
4. Have you had any recent domestic or international travel in the last 14-21 days?		
5. Have you been in contact with anyone who came from overseas in the last 14-21 days?		
6. Has anyone arrived to your home or work from overseas in the last 14-21 days?		
7. Are you experiencing any flu-like symptoms?		
8. Any fever?		
9. Any headache?		
10. Any loss of smell?		
11. Any dry coughing?		
12. Any throat pain?		
13. Any tightness in the throat?		
14. Any increased shortness of breath with activity?		
15. Any chest pain?		
16. Any back pain, muscle pain, or leg pain?		
17. Any nausea without vomiting?		
18. Any vomiting?		
19. Any abdominal discomfort?		
20. Any eye symptoms, including redness or watering?		
21. Any skin changes or manifestations?		
22. Any repeated body chills?		
23. Are you able to hold your breath for 30 seconds to 1 minute?		
24. Have you been tested for COVID-19 in the last 6 months? (nasal swab)		
If YES – how many times and what were the results?		
25. Have you been tested for COVID-19 Antibodies in the last 6 months? (blood draw)		
If YES – how many times and what were the results?		
ADDITIONAL COMMENTS/SYMPTOMS		
PHYSICIAN'S COMMENTS		

_____ _____

Patient's Signature Physician's Signature

_____ _____

Date Date

2021 Annual Wellness Exam Assessment

Last Name:_____ First Name:_____ DOB:_____ Date:_____

1. Can you get to places out of walking distance without help?
   * For example, can you travel alone by bus, taxi, or drive your own car?
   - ☐ Yes
   - ☐ No

2. Can you shop for groceries or clothes without help?
   - ☐ Yes
   - ☐ No

3. Can you prepare your own meals?
   - ☐ Yes
   - ☐ No

4. Can you do your own housework without help?
   - ☐ Yes
   - ☐ No

5. Can you handle your own money without help?
   - ☐ Yes
   - ☐ No

6. Do you need help eating, bathing, dressing, or getting around your home?
   - ☐ Yes
   - ☐ No

7. Are you having difficulties driving your car?
   - ☐ No
   - ☐ Sometimes
   - ☐ Yes, often
   - ☐ Not applicable, I do not use a car

8. Have you been given any information to help you keep track of your medications?
   - ☐ Yes
   - ☐ No

9. How often do you have trouble taking medicines the way you have been told to take them?
   - ☐ I do not take any medications
   - ☐ Always take them as prescribed
   - ☐ Sometimes I take them as prescribed
   - ☐ Never take them as prescribed

10. During the past 4 weeks, was someone available to help you if needed help?
    *For example, if you felt nervous, lonely, got sick, needed someone to talk to, needed help with daily chores.
    - ☐ Yes, as much as I needed/wanted
    - ☐ Yes, quite a bit
    - ☐ Yes, a little
    - ☐ No, not at all

11. In the past 4 weeks, how often have you had trouble eating well?
    - ☐ Never
    - ☐ Not often
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

12. In the past 4 weeks, how often have you been bothered by your teeth or dentures?
    - ☐ Never
    - ☐ Not often
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

13. In the past 4 weeks, how often have you had trouble using the telephone?
    - ☐ Never
    - ☐ Not often
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

14. Have you been given any information to help you identify hazards in your house that might hurt you?
    - ☐ Yes
    - ☐ No

15. Do you always fasten your seatbelt when you are in a car?
    - ☐ Yes, usually
    - ☐ Yes, sometimes
    - ☐ No

2021 Annual Wellness Exam Assessment

Last Name:_____ First Name:_____ DOB:_____ Date:_____

16. Have you had sex in the past 12 months (vaginal, oral or anal)?
    - ☐ Yes
    - ☐ No

17. Have you ever had a sexually transmitted infection?
    - ☐ Yes
    - ☐ No

18. During the past 4 weeks, how much bodily pain have had?
    - ☐ No pain
    - ☐ Mild pain
    - ☐ Moderate pain
    - ☐ Severe pain

19. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
    - ☐ Very heavy
    - ☐ Heavy
    - ☐ Light
    - ☐ Very light
    - ☐ No activity

20. During the past 4 weeks, how would you rate your general health?
    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor

21. How confident are you that you can control and manage most of your health problems?
    - ☐ Very confident
    - ☐ Somewhat confident
    - ☐ Not very confident
    - ☐ I do not have any health problems

22. Over the past 2 weeks, have you experienced having little interest or pleasure in doing things?
    - ☐ Yes
    - ☐ No

23. Over the past 2 weeks, have you been feeling down, depressed or hopeless?
    - ☐ Yes
    - ☐ No

24. Are you a smoker?
    - ☐ No
    - ☐ Yes, I might quit
    - ☐ Yes, I am not ready to quit

25. Did you have a drink containing alcohol in the past year?
    - ☐ Yes
    - ☐ No

26. Have you fallen two (2) or more times in the past year?
    - ☐ Yes
    - ☐ No

27. Were you injured in any falls in the past year?
    - ☐ Yes
    - ☐ No

28. Were you hospitalized in the past year?
    - ☐ Yes
    - ☐ No

_____ _____

Signature Date

Desai Medical Center's
Preventive Care Recommendations - Male

Last Name: _____ **First Name:** _____ **Account#:** _____

DOB: _____ **Age:** _____ **Date of Encounter:** _____

*In the **Previous** column – write down the last time you had the following services*	**PREVIOUS** ●	**2021**	**COMMENT**
Eye Exam *Every 1 Year, After 35*			☐ Refused
Dental Exam *Every 6 Months, From young age*			☐ Refused
Shingles Vaccine *Once in lifetime, 2 Doses*			☐ Refused
Prevnar 13 Vaccine *1 Dose, After 65*			☐ Refused
Pneumovax 23 Vaccine *Every 5 Years, After 65*			☐ Refused
Flu Vaccine *Every 1 Year, In the Fall*			☐ Refused
COVID-19 Vaccine *Dose 1 and Dose 2*			☐ Refused
Bone Density *Every 2 Years, After 65*			☐ Refused
Low Intensity CT Screening *Annual, Ages 55 – 77* *Smoking history of 30 pack-years* *No signs or symptoms of lung cancer*			☐ Refused
Hepatitis C Screening *Once in Lifetime, Born 1946-1964*			☐ Refused
Colonoscopy Screening *Frequency depends on findings, After 45*			☐ Refused

● **Family History of <u>any</u> Medical Conditions** *(EX: hypertension, diabetes, sudden death, stroke, etc)*

● **Family History of <u>any</u> Cancer**

● **COMMENTS**

All Preventive Care Recommendation Guidelines are generalized. Guidelines may change depending on the individual's allergies, medical status, and medical conditions or changes made to the National Guidelines.

Patient's Signature: _____ **Physician's Signature:** _____

Date: _____ **Date:** _____

Desai Medical Center
Physical Questionnaire 2021

Last Name: _____ **First Name:** _____ **Account#:** _____

DOB: _____ **Age:** _____ **Date of Encounter:** _____

*Write your responses in the **Patient's Response** column*	**Patient's Response** ●	**MD Record**
NEW Medical History		
NEW Family History		
NEW Allergy		
NEW Medications		
ER Visit		
Hospital Admission		
Surgery in Last 1 Year		
Upcoming Surgery		
Travel in Last 1 Year		
Upcoming Travel		☐ Business ☐ Pleasure
12 Lead EKG		☐ Normal ☐ Abnormal
Upper GI Endo (EGD)		
Colonoscopy		
Dental Examination		
Eye Examination		
Vaccinations		
Alcohol	☐ Yes Amount: ☐ No	
Smoking	☐ Yes How much: ☐ No How long:	
Substance Use	☐ Marijuana ☐ Cocaine ☐ LSD ☐ IV ☐ Heroine	
Testicular Exam	☐ Yes ☐ No	☐ Educated
Commute to Work	Hours: New Job? Days: ☐ Yes ☐ No	
Bone Dexa Scan		

Patient's Signature: _____ **Physician's Signature:** _____

Date: _____ **Date:** _____

Desai Medical Center
Physical Questionnaire 2021

Last Name: _____ **First Name:** _____ **Account#:** _____

DOB: _____ **Age:** _____ **Date of Encounter:** _____

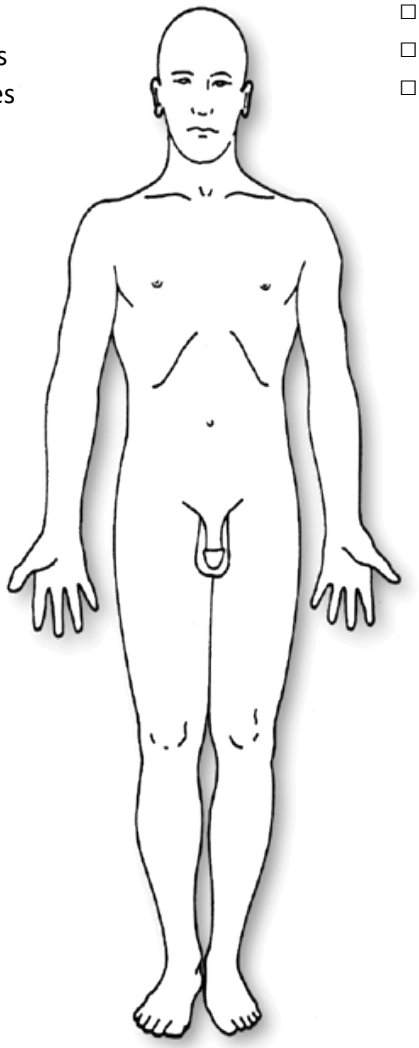
Joints
- ☐ Neck
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Fingers
- ☐ Back
- ☐ Hip
- ☐ Knees
- ☐ Ankles
- ☐ Foot
- ☐ Toes

Eyes
- ☐ Glasses Present
- ☐ How long
- ☐ Contacts
- ☐ Lasik
- ☐ Dry Eye
- ☐ Cataract

Skin
- ☐ Dry
- ☐ Scar
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Acne
- ☐ Skin Tag
- ☐ Mole
- ☐ Hair
- ☐ Tattoo

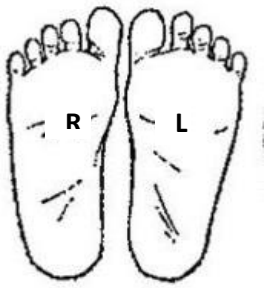
Teeth
- ☐ Stain
- ☐ Filling
- ☐ Crowding
- ☐ Cavities
- ☐ Crown
- ☐ Gums
- ☐ Manuel Dentures
- ☐ Fixed Dentures
- ☐ Full Dentures
- ☐ Partial Dentures
- ☐ Root Canal

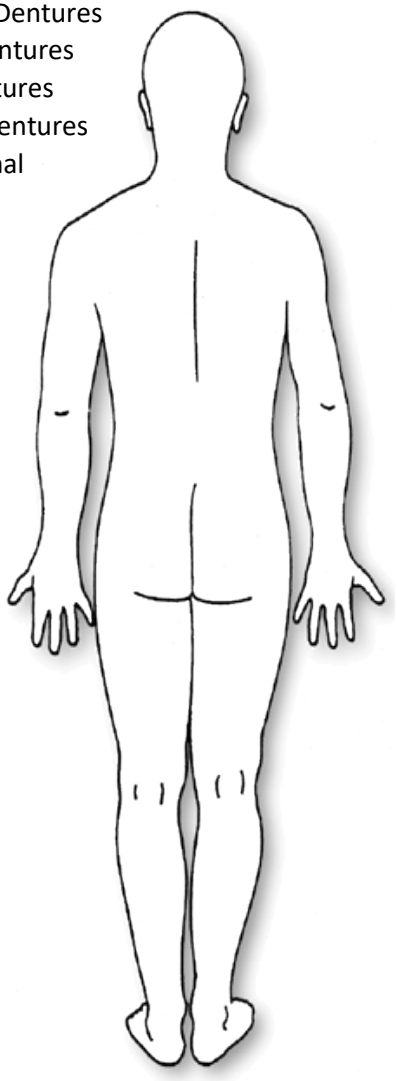
Nail
- ☐ Fungus Nail
- ☐ Nail Infection
- ☐ Overgrown Nail: Hand or Feet
- ☐ Brittle Nail: Hand or Feet



Abdomen
- ☐ Scar:
- ☐ Hernia:
- ☐ Distention

Feet
- ☐ Dry
- ☐ Callosities
- ☐ Discoloration
- ☐ Bunion
- ☐ Flat Feet





Vaccine
- ☐ COVID-19, Dose 1
- ☐ COVID-19, Dose 2
- ☐ Hepatitis B
- ☐ Herpes Zoster
- ☐ Influenza
- ☐ MMR
- ☐ Pneumovax 23
- ☐ Prevnar 13
- ☐ TB Gold
- ☐ Td/Tdap
- ☐ Zostavax

Radiology/Procedures
- ☐ Bone Density
- ☐ CT
- ☐ Mammogram
- ☐ MRI
- ☐ PET Scan
- ☐ Ultrasound
- ☐ X-Ray
- ☐ Colonoscopy
- ☐ Echocardiogram
- ☐ EGD
- ☐ Nuclear Stress Test

Consultation
- ☐ Bariatric
- ☐ Cardiology
- ☐ Dentist
- ☐ Dermatology
- ☐ Endocrinology
- ☐ Gastroenterology
- ☐ Nephrology
- ☐ Ophthalmology
- ☐ Orthopaedic
- ☐ Podiatry
- ☐ Rheumatology
- ☐ Urology

ADDITIONAL COMMENTS:

PATIENT CARE TEAM

Last Name:_____ First Name:_____ DOB:_____ Date:_____

Please tell us about the other doctors, therapists, and healthcare workers involved in your care so we can better manage and coordinate your health.

Specialty/Role	First & Last Name	Practice/Organization	Address	Phone	Last Visit
Cardiologist					
Dentist					
Dermatologist					
Endocrinologist					
Gastroenterologist					
Gynecologist					
Nephrologist					
Ophthalmologist					
Orthopaedic					
Podiatrist					
Pulmonologist					
Rheumatologist					
Urologist					

_____ _____

Signature Date