Wellness Checkup Form

Please complete this checklist before seeing your clinician. Your responses will help you receive the best health care possible.

Patients Name:_____ DOB:_____ Todays Date:_____

Please list your emergency contact person: _____

Relationship to you:_____

Phone number of contact:_____

Do you have any of the following in place (Circle): Health Care proxy Advance Directive DNR NONE

1) What is your age?

☐ 60-69 ☐ 70-79 ☐ 80 or older

2) Are you a male or female?

☐ Male ☐ Female

3) Over the last 4 weeks, how often have you been bothered by any of the following problems?

	Not at all	Few Days	Several Days	Every Day
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself-or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9) Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

Wellness Checkup Form

4) If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, get along with other people ?(circle one)

Not Difficult at all Somewhat Difficult Very Difficult Extremely Difficult

5) Do you require help with preparing meals? ☐ Yes ☐ NO

6) Do you require help with transportation? ☐ Yes ☐ NO

7) Do you require help with shopping? ☐ Yes ☐ NO

8) Do you require help with taking your medicine? ☐ Yes ☐ NO

9) Do you require help with managing your finances? ☐ Yes ☐ NO

10) Do you require help with other usual activities of daily living? ☐ Yes ☐ NO

11) Do you live alone? ☐ YES ☐ NO, and whom do you live with:_____

12) During the past four weeks, how much bodily pain have you generally had?

No Pain Very Mild Pain Mild Pain Moderate Pain Severe Pain

Where is this pain located:_____

13) During the past four weeks was someone available to help you if you needed and wanted help?

No If yes whom: _____

14) During the past four weeks what is level of physical activity you are able to complete for at least 2 minutes straight?

Very Heavy Heavy Moderate Light Very Light

15) Are you having any difficulties Driving your car? ☐ Yes ☐ NO

If yes explain: _____

16) Do you have any concerns about your memory? ☐ Yes ☐ NO

17) Do friends or family have concerns about your memory? ☐ Yes ☐ NO

18) Have you fallen in past 3 months? ☐ YES ☐ NO

19) Are you a current Smoker? ☐ YES ☐ NO

20) Are you a former smoker? ☐ YES ☐ NO

21) During the past four weeks how would you rate your health I general?

Excellent Very Good Good Fair Poor

Current Medications List

Name: _____

Date Last Updated: _____ Prescription Medications:

Name of Medication	Strength and Frequency	Condition Medication Taken For

Allergies

Pharmacy/Prescription Drug Plan

Yuko Family Medicine

WE ARE HERE FOR YOU

Please List Any Specialist/ Clinicians you see or have seen in the past 3 years

(Examples: Therapist, Psychiatrists, Dermatologist, Cardiologist, Neurologist)

Have **NOT** Seen any specialists (please check if this applies): ☐

Below please provide Name, Specialty, Location, and last time you saw each clinician

1)

2)

3)

4)

5)

6)

7)

8)

9)

10)

Yuko Family Medicine Preventive Medicine Contract

Our Practice values the importance of preventive health and will recommend preventive care steps and goals depending on your overall health, your gender and your age. A comprehensive preventive care program can lower your odds of becoming another statistic. You may not be able to control every medical condition, but following preventive care guidelines may lessen your chances of serious illness or moderate some symptoms. The below are numerated preventive measures we ask of all our patients to follow. Please read the below and sign our Patient Preventive Wellness Contract.

1. **Annual Physicals**
   All patients should receive a physical at least once a year. Patients with chronic problems, such as diabetes or thyroid issues, should see Dr Yuko McColgan or specialist treating the issue twice a year.
2. **Vision Exams every 2 years**
   All patients should receive vision exams at least every 2 years. Patients with known vision problems should receive more frequent eye exams. Diabetics/Prediabetics should receive yearly dilated eye exams.
3. **Routine Yearly Dental Visits**
   Patients with known problems should visit the dentist more frequently.
4. **Yearly Mammograms for women ages 40+**
   All female patients ages 40 and above should receive a yearly mammogram. Female patients with abnormal results or known problems should receive more frequent mammograms.
5. **Colonoscopy every 5-10 years for men and women ages 50+**
   All patients ages 50 and above should receive a colonoscopy every 5 to 10 years. Patients with abnormal results or known problems should receive more frequent colonoscopies.
6. **Pap smears every 2-3 years for women ages 23+ or sexually active**
   All female patients ages 23 and above or sexually active should receive a pap smear every 2 to 3 years. Patients with abnormal results or known problems should receive more frequent pap smears.
7. **Vaccinations**
   All Patients 18 years or younger must be vaccinated in accordance to CDC and State of Massachusetts school Guidelines. Adults 18+ must have an active Tdap vaccine and prior history of MMR, Varicella and Hep B vaccinations.

You have read the above and agreed to the carry through these preventive measures to the best of your efforts.

_____

Patient Full Name

_____

Signature of Patient/ Parent of Patient *Date*