GWINNETT CLINIC

Congratulations on prioritizing your health and wellness!

ANNUAL WELLNESS VISIT
(NON-MEDICARE)

Date: _____

Location: _____

Physician/NP: _____

PATIENT SECTION

- Complete this form in its entirety.
- Bring all of your medication bottles.
- Register for the patient portal to receive your lab results.
- On the day of your visit, please drink plenty of water.
- You do not need to fast unless specifically instructed by your physician/NP.

Name: _____ Best contact number: _____

Date of birth: _____ Age: _____ Race: _____ Sex: _____

Marital status: ☐ Single ☐ Married ☐ In a Relationship ☐ Divorced ☐ Widowed

GENERAL HISTORY

Education (Years/Degree): _____ Occupation: _____

Living situation: ☐ Alone ☐ w/Family ☐ Assisted living ☐ Nursing home ☐ Other: _____

On average, **how many days per week** do you do moderate to strenuous exercise, like a brisk walk or jog? _____

Do you currently use tobacco or nicotine products?

☐ Never ☐ Not currently, but yes in the past ☐ Yes, the product used is: _____ Years used: _____

Do you want to quit? ☐ Yes ☐ No

On average, how many drinks with alcohol (servings) do you have **per week?** ☐ None ☐ 1 to 2 ☐ 3 to 4 ☐ 5 or more

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

Little interest or pleasure in doing things: ☐ Never ☐ Several days ☐ Most days ☐ Almost daily

Feeling down, depressed or hopeless: ☐ Never ☐ Several days ☐ Most days ☐ Almost daily

Are you concerned about your sleep? ☐ Yes ☐ No Average hours of sleep per night: _____

Do you snore? ☐ Yes ☐ No

Have you ever been sexually active? ☐ Yes ☐ No With: ☐ Males ☐ Females How many lifetime partners? _____

Many sexually transmitted infections (STI) do not have symptoms you can see or feel. That's why it's important to get tested. Today's routine laboratory evaluation can include HIV, syphilis, gonorrhea, and chlamydia testing - most insurances cover these tests once per year without charge. **Do you want STI testing today?** ☐ Yes ☐ No

MEDICAL HISTORY

Please check if you have, or have ever had, any of the following conditions:

☐ High blood pressure	☐ High cholesterol	☐ Heart disease: _____	☐ Asthma
☐ COPD	☐ Lung disease: _____	☐ Sleep apnea	☐ Headache
☐ Depression	☐ Anxiety	☐ Mental health: _____	☐ Stroke
☐ Bleeding disorder	☐ Blood clots	☐ Acid reflux	☐ Thyroid disease: _____
☐ Arthritis: _____	☐ Diabetes: ☐ Adult ☐ Childhood	☐ HIV	☐ Hepatitis
☐ Heavy/Irregular/Painful period			

List any medical conditions not listed above: _____

_____

_____

_____

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Physician/NP: _____

PATIENT SECTION

IMMUNIZATION HISTORY

Did you receive all of your childhood immunizations (pediatric, MMR, Varicella/Chickenpox, Hepatitis A/B, HPV, and others)? ☐ Yes ☐ No ☐ Not sure

Please check if you need any of the following adult immunizations. (For vaccines that may require boosters, write the year you most recently received it.) ☐ Flu (annually | ____yr) ☐ Tdap/Tetanus (every 10 years | ____yr) ☐ COVID (2+ shots | ____yr) ☐ Pneumonia (once in lifetime) ☐ Shingles (2 shot series once in lifetime) ☐ RSV (once in lifetime)

PREVIOUS TESTS

Please list the year of the last test for each of the below. Leave blank if you have not had it.

Bone density: _____ Heart stress test: _____ Colonoscopy: _____ Mammogram: _____ Pap smear: _____

For patients with diabetes and/or high blood pressure: Eye exam: _____ Urine protein test: _____

For patients age 50 to 80 years who have smoked cigarettes/cigars for at least 20 years: Lung cancer screening CT scan: _____

FAMILY HISTORY

Mother Age: _____ Health problems: _____ *Father* Age: _____ Health problems: _____

Family health problems or conditions (first degree relatives only): _____

_____

Do you have any known family history of these cancers? ☐ Breast Cancer ☐ Cervical Cancer ☐ Colon Cancer ☐ Prostate Cancer

ALLERGIES

List any allergies to medications or foods. Include the type of reaction caused. _____

_____

_____

Do you want to be referred to allergy clinic for food allergy or medication allergy testing? ☐ Yes ☐ No

CURRENT MEDICATIONS (FOR ESTABLISHED PATIENTS: PLEASE ADD NEW INFORMATION ONLY)

List any medications you take along with the dose and frequency. Attach a list if needed. _____

_____

_____

SURGICAL HISTORY (FOR ESTABLISHED PATIENTS: PLEASE ADD NEW INFORMATION ONLY)

List all prior surgeries. _____

_____

_____

REVIEW OF SYSTEMS (FOR ESTABLISHED PATIENTS: PLEASE ADD NEW INFORMATION ONLY)

☐ **NO CHANGE FROM LAST GWINNETT CLINIC PRIMARY CARE VISIT**

Please list any health complaints or concerns you would like to have addressed below. **Please note:** today's visit is only for your prevention and wellness. A separate office visit will be scheduled to address these health complaints or concerns, but your doctor will have your complete history and blood work for the follow-up visit. _____

_____

_____

_____

_____

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PHYSICIAN SECTION

VITAL SIGNS

TEMP _____ HR _____ RR _____ BP _____ HT _____ WT _____ BMI _____ WAIST _____(in)

PHYSICAL EXAM

Check if normal findings. If abnormal findings, describe and circle the specific one(s).

GENERAL: ☐ Well nourished ☐ Well developed ☐ No acute distress ☐ N ☐ Abn _____

HEAD, EARS: ☐ NC/AT ☐ TM Normal light reflex ☐ N ☐ Abn _____

EYES: ☐ Sclera white ☐ Normal conjunctiva ☐ PERRL ☐ EOMI ☐ N ☐ Abn _____

NOSE/THROAT: ☐ Nares pink and moist ☐ Oropharynx clear ☐ No exudates ☐ N ☐ Abn _____

NECK: ☐ Supple, Trachea midline ☐ No thyromegaly ☐ No lymphadenopathy ☐ N ☐ Abn _____

CARDIOVASCULAR: ☐ RRR ☐ No murmurs/gallops/rubs, normal PMI ☐ N ☐ Abn _____

RESPIRATORY: ☐ CTAB ☐ No wheeze/rhonchi/rales ☐ N ☐ Abn _____

GI / ABDOMEN: ☐ Soft, NT/ND, normal bowel sounds ☐ No organomegaly ☐ N ☐ Abn _____

NEURO: ☐ CN II-XII intact ☐ Deep Tendon Reflex intact ☐ Gross sensation intact ☐ N ☐ Abn _____

MSK: ☐ 5/5 strength bilateral upper and lower extremities ☐ Normal ROM ☐ Normal gait ☐ N ☐ Abn _____

SKIN: ☐ Warm, dry, normal turgor ☐ No clubbing/cyanosis/edema ☐ No rash or ulcer ☐ N ☐ Abn _____

PSYCH: ☐ Alert/oriented x 3 ☐ Normal affect/insight/judgment ☐ Normal memory ☐ N ☐ Abn _____

Other: _____

_____

ASSESSMENT/PLAN

_____

_____

Screening Labs: ☐ CBC ☐ CMP ☐ Lipids ☐ TSH ☐ HgbA1C ☐ PSA ☐ Urine GC/CT ☐ HIV ☐ T Pallidum/Syphilis

Additional Labs (may incur charge): ☐ Vitamin B12 ☐ Vitamin D ☐ Blood type ☐ Other: _____

Screening Tests: ☐ Mammogram ☐ Bone density ☐ Colonoscopy ☐ LDCT

Vaccines:

☐ Flu LOT _____ EXP ____ L or R Deltoid ☐ VIS given ☐ Tdap LOT _____ EXP ____ L or R Deltoid ☐ VIS given

To be ordered for administration at pharmacy or health department: ☐ Pneumonia ☐ HPV ☐ Shingles ☐ COVID ☐ RSV

Follow-up/Referrals:

☐ Well Women Visit with Pap
☐ Well Women Visit without Pap
☐ Mental Health Consultation
☐ Sleep/Snoring Consultation
☐ Weigh Management Consultation
☐ Food Allergy Consultation
☐ Substance Abuse (Tobacco/Alcohol) Consultation _____
☐ Cardiac Preventative Consultation
☐ _____
☐ _____

Return Appointment: _____ **Initial of Medical Assistant:** _____

Physician/NP Signature: _____ **Date:** _____

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