Family Practice Associates of Chesterfield
13911 St Francis Blvd-Ste 101-Midlothian, VA 23114

Annual Wellness Exam

Patient's Name: _____ Patient's DOB _____

Patient's History:

Check "yes" or "no" if there have been any changes to the following information since your last visit?

Medical History	Yes ___ No ___	Family History	Yes ___ No ___	Medications	Yes ___ No ___
Surgical History	Yes ___ No ___	Social History	Yes ___ No ___	Allergies	Yes ___ No ___

If you checked "Yes" to any of the above, please add changes here:

_____

_____

_____

For Coordination of Care: List all Specialist/Providers you see outside of this Practice

Example: John Smith-Urologist_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Screening & Immunization Dates

Influenza: _____ Dtap: _____

Covid: _____ Colonoscopy: _____

RSV: _____ Cologuard/FIT Test: _____

Shingrix: _____ Mammogram: _____

PCV 20 (Prevnar 20): _____ Pap Smear: _____

PCV 21 (Capvaxive): _____ Dexa Scan: _____

Pneumonvax 23: _____ OTHER: _____

Health Risk Assessment

*Do you worrry about falling? _____

*Do you feel unsteady walking or standing? _____

*Have you fallen within the past year? _____

If yes, How many time(s)_____

*Can you prepare your own meals? _____

*Can you handle housework without help? _____

*Can you shop for food/clothes without help? _____

*Do you experience urine leakage? _____

*Do you smoke or use tobacco products? _____

*Do you have an Advance Care Directive? _____

Copy in Chart ____ Family member _____

*Can you handle your finances without help? _____

*Can you comfortably cover your medication costs? _____

*Do you take Aspirin daily?

If yes, what dose are you taking? _____

*Have you noticed any problems with memory issues? ___

*Have your family/friends expressed any concerns regarding your memory? _____

Health Risk Assessment Continued

IN THE PAST 4 WEEKS HAVE YOU EXPERIENCED:

*Choose the hardest physical activity you could do for at least 2 minutes?

very heavy ___ heavy ___ moderate ___ light ___ very light ___

*How do you rate your general health?

excellent ___ very good ___ equally good and bad ___ pretty bad ___ very bad ___

*Do you need help with eating, bathing or getting around your home? _____

*Are you having difficulties driving your car?

no ___ sometimes ___ at night ___ yes ___ I don't drive ___

*Do you always use your seatbelt? Yes____ sometimes ____ no ____

*Do you experience pain on a daily basis? _____

If yes, rate your pain on a scale of 1-10 _____

*Do you take any Opioid medication? _____

If yes, is your current dose managing your pain? yes / no

*Do you have any other trouble with your day to day living? _____

_____

Unless you decline, we will send lab results, prescription refills and messages to you through the portal.

Email: _____

Local Pharmacy _____ Mail Order Pharmacy_____