THE MURPHY CLINIC
INTERNAL MEDICINE, ADDICTION MEDICINE, ACUPUNCTURE
& CONCIERGE PRACTICE

ANNUAL WELLNESS EXAM SCREENING

NAME: ______________________________ **DATE OF BIRTH:** ____________ **DATE:** ______________

ADL

Do you need assistance to bath or groom? ❑ Yes ❑ No

Do you need assistance with toileting? ❑ Yes ❑ No

Do you need assistance with eating? ❑ Yes ❑ No

VISION

Do you or people around you have concerns about your vision? ❑ Yes ❑ No

FALL RISK

Do you use any mobility equipment? (Examples: Cane, Walker, Rollator etc.) ❑ Yes ❑ No

In the past 12 months have you had a problem with balance, walking or feeling unsafe on your feet? ❑ Yes ❑ No

In the past 12 months have you had a fall? ❑ Yes ❑ No

In the past 12 months have you had an injury from a fall? ❑ Yes ❑ No

Does your home have any trip hazards? (Examples: Uneven floors, throw rugs, etc) ❑ Yes ❑ No

INCONTINENCE

How much urinary incontinence do you experience? ❑ None ❑ Some ❑ Always

COGNITIVE

Do you or people around you have concerns about your memory? ❑ Yes ❑ No

ADVANCED DIRECTIVES

Do you have advance directives in place? ❑ Yes ❑ No

LIFESTYLE

With whom do you live? (Spouse, Friend, Child, Grandchild, Nursing Home, Other) ____________________

How many stories is your home? ❑ One ❑ Two ❑ Three

Type of residence? ❑ Single Family Home ❑ Apartment ❑ Skilled Nursing Facility or Assisted Living

Do you have smoke detectors in your home? ❑ Yes ❑ No

Are you able to afford your medication? ❑ Yes ❑ No

Have you had any unexpected weight gain in last 6 months? ❑ Yes ❑ No

How much physical activity/exercise do you get? ❑ None ❑ Little ❑ Moderate ❑ Everyday

Alcohol/ Tobacco Use

Do you use alcohol? ❑ Yes ❑ No How much?________________________

Do you use tobacco? ❑ Yes ❑ No How much?________________________

Personal Habit Review

Have you seen a dentist in the last 12 months? ❑ Yes ❑ No

Do you wear a seatbelt on a regular basis? ❑ Yes ❑ No

Do you wear sunscreen on a regular basis? ❑ Yes ❑ No

Are you sexually active? ❑ Yes ❑ No

In general, how do you rate yourself compared to others your age? ❑ Same ❑ Worse ❑ Better

How is your health today compared to last year? ❑ Same ❑ Worse ❑ Better

PHQ-9

In the last two weeks have you had any of the listed feelings:

Feeling bad about yourself, or that you are a failure or let you or your family down? ❑ None ❑ Some days ❑ More than Half ❑ Everyday

Feeling down, depressed or hopeless? ❑ None ❑ Some days ❑ More than Half ❑ Everyday

Feeling tired or having little energy? ❑ None ❑ Some days ❑ More than Half ❑ Everyday

Little interest or pleasure in doing things? ❑ None ❑ Some days ❑ More than Half ❑ Everyday

Moving or speaking so slowly that other people could have noticed or being fidgety or restless more than usual? ❑ None ❑ Some days ❑ More than Half ❑ Everyday

Poor appetite or overeating? ❑ None ❑ Some days ❑ More than Half ❑ Everyday

Thoughts that you would be better off dead or hurting yourself? ❑ None ❑ Some days ❑ More than Half ❑ Everyday

Trouble concentrating on things like reading the paper or watching television? ❑None ❑Some days ❑More than Half ❑Everyday

Trouble falling, staying asleep or sleeping too much? ❑ None ❑ Some days ❑ More than Half ❑ Everyday

Do you have a family history of Diabetes? ❑ Yes ❑ No

Screenings & Vaccinations:

Mammogram Date____________________ ❑ Normal ❑ Abnormal
Patients over 40 or with family history

Bone Density Date____________________ ❑ Normal ❑ Abnormal
Patients postmenopausal or with symptoms every two years

Colon Cancer Date____________________ ❑ Normal ❑ Abnormal
Patients 50 + or with family history

PAP Date____________________ ❑ Normal ❑ Abnormal

Prostate Cancer Date____________________ ❑ Normal ❑ Abnormal
Male patients over 40

Cholesterol Screening Date____________________ ❑ Normal ❑ Abnormal

AAA Screening Date____________________ ❑ Normal ❑ Abnormal
Recommended for male patients between 65 and 75 who have ever smoked

Hepatitis C Screening Date____________________ ❑ Normal ❑ Abnormal
Recommended for patients born between 1945 and 1965

Flu Shot Date____________________

Pneumonia (Prevnar 13) Date____________________

Pneumonia (Pneumovax 23) Date____________________

Shingles (Zostavax) Date____________________

Shingles (Shingrix) Date____________________

Tetanus Date____________________

Hepatitis B Date____________________

Covid Vaccine Dates____________________

Other Date____________________ Name ____________________________

Other Date____________________ Name ____________________________

Please list any changes to your medical or surgical history since you have been seen. (surgeries or medical conditions Dr. Murphy may not be aware of)

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Please list any specialists that you see and reason.

Specialist Reason

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