Name

THE MURPHY CLINIC

INTERNAL MEDICINE, ADDICTION MEDICINE, ACUPUNCTURE
& CONCIERGE PRACTICE

Annual Wellness

Name_____ Date of Visit_____

Date of Birth_____

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 you vision? Yes No

Fall Risk

Do you use any mobility equipment? cane, walker etc. Yes No

If so which one? Cane. Walker. Other_____

In the past 12 months have you had a problem with balance,

Walking or feeling unsafe on you feet? Yes No

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

If yes, how many falls in the past 12 months? _____

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

Does you home have any trip hazards? Uneven floors, 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

Name _____

Lifestyle review

Who do you live with? spouse, friend, nursing home, other _____

How many stories is your home? 1 2 3

Type of residence? Single family home Apartment Nursing home

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 often do you have containing alcohol? _____

How many drinks containing alcohol did you have on a typical day when you were drinking? _____

How often did you have six or more drinks on one occasion in the past year?

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

Name _____

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 paper or watching television?

None. Some days more than half everyday

Trouble falling or staying asleep or sleeping too much?

None Some days. More than half everyday

Do you have a family history of Diabetes Yes No

Do you have any loss of sensation in either foot? Yes No

If you have Diabetes, who is your Ophthalmologist(that does your eye exams?_____

When was your last eye exam? _____

When was your last diabetic foot exam? Who was the physician _____

Have you ever been diagnosed with COPD? Yes No

Do you see a cardiologist? Yes. No.

If yes, Who is it? _____

When was your last visit?_____

Name _____

Screenings:

Mammogram Date_____ Normal Abnormal

Pts over 40 or with family history

Bone Density Date_____ Normal Abnormal
Pt 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
Recommends for male patients between 65 and 75 who have ever smoked

Hepatitis C Screening Date_____ Normal Abnormal
Recommends 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_____

Other Date_____ Name _____

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)

_____

_____

_____

_____

_____

Please list any specialists that you have recently seen and reason.

Specialist Reason

_____

_____

_____

_____

_____