Hunterdon Healthcare Practices
Adult Wellness Pre-Visit Patient Packet for age 18-64 years

Name___________________________________ Date of Birth_____________________

Welcome to your Wellness Visit-It's Not Just a Physical Anymore!

We are looking forward to seeing you at your upcoming preventive care visit, where we will focus on creating a **wellness plan** customized for you, including the following:

- address screenings for cancer, depression, heart disease and other health problems (screening means checking for problems that were not previously diagnosed, not managing conditions you know you have)
- make sure your vaccinations and appropriate testing are up to date
- talk about nutrition, exercise, stress and other factors affecting your health
- update your family history
- make sure your healthcare wishes are respected by creating an Advance Directive
- make sure ALL of your medications are appropriate, safe, and as affordable as possible
- address what is important to YOU

On the day of your visit:

- Be sure to bring your valid insurance card with you.
- Blood tests: If you need fasting blood work for cholesterol or blood sugar, please don't eat food for 5 hours prior to your appointment, but drink plenty of water or non-caloric drinks (black coffee or tea are fine!). Take your medications as usual.
- Urine sample: you may be asked for a urine sample at the office.
- Please bring a list of your medications, or bring the medications themselves! Include all over the counter products you take.

We want to spend our time together to focus on what is most important to you. Please complete the questionnaire below and bring it with you on the day of your visit so we spend less time collecting information and more time on what matters!

If you must cancel your appointment, please give us at least 24 hours' notice.

Frequently asked questions:

Is preventive health care covered by insurance?

In the past, some people skipped preventive care visits because they were not covered by insurance. However, almost all insurance plans now cover your **visit** with your primary care doctor each year with no co-pay or deductible to be sure you can create and follow your own Wellness Plan

A **preventive or "well" visit** focuses on staying as healthy as possible. Medical problems like pains, fatigue, constipation, diabetes, heart problems, lung problems etc. are addressed at **sick or disease management visits**. These problems require a different history, review of past treatments, lab tests and x-rays, and medication management.

If we combine a problem visit with your well visit, we will submit the appropriate codes and charges to your insurance company for both the well visit and the problem visit. This is the correct and accepted way to bill for this type of appointment. Depending on your insurance plan, you may be responsible for a portion of the bill.

I have heard about Medical Homes – what are they?

A Medical Home is not a building or a place. It's a way your primary care doctor partners with you and your family in order to work together in the office AND between visits while helping to coordinate care with other doctors and hospitals.

Health questions to answer and bring to your visit:

1. Have you ever used tobacco? **No** **Yes**
   a. If **yes**, did you or do you use it daily? **No** **Yes**
   b. What type of tobacco? _______
   c. How much did you or do you smoke? _______ cigarettes/day *or* _______ pack(s)/day
   d. What age did you start? _______
   e. If you stopped, what age did you stop? _______

2. Have you ever used e-cigarettes or vaped using Juul or another device*?* **No** **Yes**
   a. If **yes**, did you or do you use it daily? **No** **Yes**
   b. At what age did you start? ____________
   c. What type of device did/do you use? ____________
   d. What nicotine strength did/do you use? ____________
   e. If you stopped, what age did you stop? ____________

3. How often do you have a drink containing alcohol?

Never **(skip to question 5)**
Once monthly or less
2-4 times a month
2-3 times a week
4 or more times a week

How many standard drinks containing alcohol do you have in a typical day when you drink?

1 or 2
3 or 4
5 or 6
7 to 9
10 or more

How often do you have six or more drinks on one occasion?

Never
Less than monthly
Monthly
Weekly
Daily or almost daily

4. Within the past 12 months, I/we have worried about whether our food would run out before we had enough money to buy more: **Circle one → Often Sometimes Never**

Within the past 12 months, the food I/we bought just didn't last and we didn't have money to get more: **Circle one→ Often Sometimes Never**

5. Exposure to Violence Circle (yes) or (no) or decline to answer (N/A)

In the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? **No Yes N/A**

In last year, have you been afraid of your partner or ex-partner? **No Yes N/A**

Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? **No Yes N/A**

Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? **No Yes N/A**

6. **Advance Care Planning**
Do you have an advance directive (living will)? **No** **Yes**

Do you have a healthcare proxy to make decisions for you if you are unable to do so? **No** **Yes**
If "yes", please be sure we have the most recent copies!

7. Do you have concerns about your memory? **No** **Yes**

8. **How have you been feeling?**

In the past two weeks:	**Not at All**	**Several Days**	**More than half the days**	**Nearly every day**
Have you been bothered by having little pleasure in doing things?				
Have you been bothered by feeling down depressed or hopeless?				
Trouble falling or staying asleep, or sleeping too much?				
Do you feel tired or have too little energy?				
Poor appetite or overeating?				
Feeling bad about yourself or that you are a failure or have let yourself or your family down?				
Trouble concentrating on things, such as reading the newspaper or watching television?				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual?				
Thoughts that you would be better off dead, or of hurting yourself?				

- If you are over age 45: when was your last colonoscopy (colorectal cancer screening test)?
  - Where was it done?

- If you have high blood pressure, have you ever had an EKG (cardiogram)?
  - When was it done?
  - Where was it done?

- If you have diabetes, when was your last eye doctor exam?
  - Where was it done?

9. How would you describe your physical activity level

- ☐ **None -** You are not physically active and spend most of your time sitting or resting.
- ☐ **Low** - You are physically active 1 to 2 days per week.
- ☐ **Medium** - You are physically active 3 to 4 days per week.
- ☐ **High** - You are physically active 5 or more days per week.

10. Please be sure we have a complete record of all your vaccines

- If you had a vaccine elsewhere, please bring your record
  - Examples: COVID, flu vaccine, pneumonia vaccine, shingles vaccine, tetanus vaccine, hepatitis vaccine, etc.

11. Remember to bring a list of your medications, or the medications themselves! Include over the counter products.

<u>If you are age 65 or older:</u>

- Have you fallen in last year? **No Yes**
  - If so, how many times? _____
  - Did the falls result in injury? **No Yes**

- Do you take four or more medicines per day? **No Yes**

- Do you feel unsteady or have problems with balance? **No Yes**

- Do you have a hard time getting up from a chair? **No Yes**

Women

- Do you see a gynecologist (Ob/Gyn)?
    - If so, whom?

- When was your last PAP smear (cervical cancer test)?
    - Where was it done?

- If you are over age 40:
    - When was your last mammogram (breast cancer screening test)?
    - Where was it done?

- If you are over age 65:
    - Have you had a bone density test for osteoporosis, also called dexa scan)?
        - When was it done?
        - Where was it done?

Please list other doctors who take care of you:

Specialty	Name	Address	Phone Number

Have you had any surgeries since your last visit? If so, please write the surgery and date below. New patients, please list all surgeries you have had.

Have you had any new medical diagnoses since your last visit? If so, please write the diagnoses and date below. New patients, please list all of your medical conditions.

Please update your **family history** for us: Any new diagnoses for your parent, sibling, son or daughter? If so, please write the person's relationship to you and the diagnosis. New patients, please list diagnoses for your family members.

Please update your **employment history** for us:

Use this space to write questions you have for the doctor or nurse at your visit: