

What should you bring to your Annual Wellness Visit?

The names of all of your doctors:

Name:	Specialty:

An up to date list of all of your medications:

Name of Medicine:	Dose/Frequency:

Have any of your close relatives had any health changes? ___ Yes ___ No

Has your mood changed? ___ Yes ___ No

Do you worry about falling? ___ Yes ___ No

Are you worried about your memory? ___ Yes ___ No

Are you any preventative tests that you have done recently?
(lab test, mammogram, xray, colonoscopy, dexta scan) ___ Yes ___ No

Have you had any recent immunizations?
(please bring the records with you) ___ Yes ___ No

Do you have a living will or an advance directive?
(If you have one, please bring a copy with you) ___ Yes ___ No

Do you receive any home health services?
(Nursing Care, Therapy, Aide, Durable Medical Equipment)
Company: _____ ___ Yes ___ No