Name: _____
DOB: _____
Address: _____

Silver Pine Medical Group

Please Complete & Bring back to your **Annual Wellness Visit**

List the names of your doctors and their specialty below:

Name of Doctor:	Specialty:

List all of your medications and their doses below:

Name of Medicine:	Dose:

Please list any immunizations or preventative tests (labs, x-rays, etc.) you've had recently & where they were completed.

Immunizations:	Location:
Flu	
Pneumovax	
Prevnar	
Tetanus	
Tests:	**Location:**
Colonoscopy	
Mammogram	
Retinal Eye Exam	

If you have a living will or advanced directive, please **bring** it to your next appointment.

Feel free to discuss any questions or concerns with your provider

Name: _____
DOB: _____
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Silver Pine Medical Group

Please check **yes** or **no** to the following questions. Some have follow-up questions, please answer accordingly. This information will be kept confidential.

Questions:	Yes:	No:
1. Are you worried about your memory?		
2. Have any of your close relatives had any health changes?		
3. Do you have trouble taking your medications the way you have been told?		
4. In the past year, have you ever had to go without health care because you did not have a way to get there?		
5. In the last year, have you needed to see a doctor, but could not because of cost?		
6. Do you need help controlling/managing your health problems?		
7. In the past month, have you felt more tired or fatigued?		
8. During the past month, have you felt bodily pain? If yes, to what degree? (very mild, mild, moderate severe) _____		
9. During the past month, have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, downhearted or blue?		
10. In the past month, have you had sexual problems?		
	Yes:	**No:**
11. Are you having difficulties driving your car? If yes, how often? _____		
12. Are you afraid you might get hurt in your home?		
13. Do you need information to help with hazards in your house that might hurt you?		
	Yes:	**No:**
14. Are you having difficulty exercising for 20 minutes at least 3 or more days a week?		
15. In the past month, did poor physical or mental health keep you from doing your usual activities, like work, spending time with family, or a hobby?		
16. Do you need help shopping for groceries or clothes?		
17. In the last year, did you ever eat less because there wasn't enough money for food?		
18. Do you need household items? Ex: Clothing, shoes, blankets, groceries, etc.		
19. Do you need help preparing your own meals?		
20. Do you need help eating?		
21. Do you need help bathing?		
22. Do you need help getting dressed?		
23. Do you need help with housework?		
24. Do you need help handling your money?		
25. Do you have problems using the telephone to make a call?		
26. Are you worried that in the next 2 months you may not have stable housing?		
27. In the last year, has your utility company shut off your services for not paying your bills?		
28. If any of the above questions are checked **YES**, would you like to receive assistance with any of these needs?		