Annual Wellness Exam

Date of assessment: _____

Patient information		
Name:	Date of birth:	
Age:	Gender:	
Height:	Weight:	
Contact information:		
Health risk assessment		
Demographics completed?	☐ Yes	☐ No
Self-rated health status:		
☐ Excellent	☐ Good	
☐ Fair	☐ Poor	
Medical history (chronic conditions, surgeries):	Family history (hereditary conditions):	
Behavioral risks (e.g., tobacco use, alcohol):	Psychosocial risks (e.g., depression, isolation):	
Activities of daily living (ADLs) functional status:	☐ Independent	☐ Needs assistance
If they need assistance, please specify:		
Medical history review		
Past illnesses/surgeries:	Chronic conditions:	

Hospitalizations (last year):	Allergies:
Physical examination	
Vital signs	
Blood pressure: mmHg	Heart rate: bpm
Temperature: °F	Respiratory rate: breaths/min
Body mass index:	
System examination summary	
Heart:	Lungs:
Abdomen:	Skin:
Neuro:	
Gender-specific exams	
☐ Breast exam ☐ Pelvic exam ☐ Prostate exam	
Notes:	
Screening tests and immunizations	
Recommended screenings	
☐ Blood work (CBC, lipids, glucose, etc.)	☐ Colonoscopy
☐ Mammogram	☐ Pap smear
☐ Bone density scan	☐ Others:

Immunizations updated?		
☐ Influenza	☐ Tdap	
☐ Pneumococcal	☐ Shingles	
☐ COVID-19	☐ Others:	
Cognitive function assessment		
Cognitive concerns expressed?	☐ Yes	☐ No
Brief screen performed? (e.g., Mini-Cog, MoCA)	☐ Yes	☐ No
Observation/results:		
Lifestyle and behavioral review		
Diet:		
Physical activity:		
Sleep habits:		
Stress levels:		
☐ Low	☐ Moderate	☐ High
Smoking status:		
☐ Current	☐ Former	☐ Never
Alcohol use:		
☐ None	☐ Moderate	☐ Heavy
Medication review		
Current medications/supplements reviewed?	☐ Yes	☐ No

Changes made?	☐ Yes	☐ No
Details:		

Personalized prevention

Top 3 health goals

Strategies/interventions planned

Follow-up appointments or referrals

- ☐ Nutritionist:
- ☐ Behavioral health:
- ☐ Specialist:
- ☐ Next wellness exam date:

Additional notes

Healthcare professional information

Name:	License ID number:
Signature:	Date of assessment: