ADULT WELL VISIT – AGES 65 YEARS +

☐ Male ☐ Female

Name: ____________________ ID # ______________ Age: _______ DOB: ____________ ☐ **IHEBAT** ☐ **120-Day IHA**

Accompanied by: ☐ Spouse ☐ Relative ☐ Other: ______________ **Date of Visit:**____________

Wt: Lbs/oz/kg (%ile)	Ht: Inch/cm (%ile)	BMI:	B/P:	Temp : F°/C°	Vision Both :______ Rt :__________ Lt :__________	Audiometric: Rt:_____Lt:_____ RN/MA______________

MEDICAL HISTORY

Interim History
- ☐ No Problems
  - ☐ Significant Illness / Injury ______________
  - ☐ Surgeries ______________
  - ☐ Medications: ______________
  - ☐ Allergies: ______________
  - ☐ Visits to other health care provider: (name) ______________

☐ Yes ☐ No Immunizations current

Nutrition
- ☐ No Problems
  - ☐ Healthy Food Choices
  - ☐ Empty Calories Discussed
  - ☐ Weight Management

SOCIAL / FAMILY HISTORY

- ☐ No Interval Changes
  - ☐ Married ☐ Single ☐ Divorced
  - ☐ Children _______ Ages:____________
  - ☐ Work / Occupation / Retired: ____________
  - ☐ School: ______________
- ☐ Sexually Active ☐ Yes ☐ No ☐ Previously
- ☐ Menopause / LMP ___________
- ☐ Using Birth Control Method: ___________
- ☐ Exercises Regularly ______________
- ☐ Hobbies, Recreational activities
- ☐ History of Smoking ☐ Smokers in the House
- ☐ Alcohol Use / Abuse ☐ Recreational Drugs

HEALTH EDUCATION
(✓ if discussed or handout given)

- ☐ Healthy habits – adequate sleep, exercise, fluids
- ☐ Diet / Nutrition: weight control, diabetes, cholesterol, hypertension, heart disease, liver failure, renal failure
- ☐ Sexual Activity Information: STDs, HIV, Safer sex
- ☐ Menopause counseling
- ☐ Regular dental care
- ☐ Guidance: Smoking, alcohol, drugs, stress, Depression
- ☐ Injury Prevention: seat belts, helmets, sunscreen, protective sports gear, falls, gun safety
- ☐ Advanced Healthcare Directives
- ☐ Domestic violence and suicide prevention
- ☐ Anger management and conflict resolution
- ☐ Medication & IZ counseling
- ☐ Calcium, Folic Acid supplements
- ☐ ______________________________

PHYSICAL EXAM
(✓ if within Normal Limits)

NL — Comment if Abnormal

- ☐ General Appearance
- ☐ Skin
- ☐ Head
- ☐ Eyes
- ☐ E.N.T.
- ☐ Mouth /Teeth
- ☐ Lymph
- ☐ Neck
- ☐ Lungs
- ☐ Heart
- ☐ Breast
- ☐ Abdomen
- ☐ Back
- ☐ Ext/Hips/Feet
- ☐ Neurologic / Reflexes
- ☐ Groin / Hernia
- ☐ Rectal — Occult Blood + -

Females: ☐ Pelvic Exam ☐ Vagina ☐ Vulva, BUS ☐ Cervix ☐ Uterus ☐ Adnexa

Males: ☐ Circ ☐ Uncircumcised ☐ Penis ☐ Scrotum ☐ Testes ☐ Prostate

☐ Instructions in self breast exam/self testicular exam

ASSESSMENT

- ☐ Well Adult

REFERRALS

- ☐ Dietician ☐ Vision Referral
- ☐ Mammogram ☐ Hearing Referral
- ☐ Counseling ☐ Dental Referral
- ☐ Sigmoidoscopy / Colonoscopy
- ☐ Other: ______________________

IMMUNIZATIONS

- ☐ Hep B ☐ VZV ☐ Hep A
- ☐ Td ☐ Pneumococcal ☐ Influenza
- ☐ MMR ☐ Other: ___________
- ☐ Vaccine Information Statements (VIS) Given to patient
- ☐ PPD Date given: __________ Results: __________
- ☐ CXR Results: __________

LABORATORY

- ☐ Fasting Blood Glucose ☐ Pap Smear ☐ Thyroid Screen
- ☐ Cholesterol ☐ PSA ☐ Urine_______
- ☐ Chlamydia Screening (high risk individuals) ☐ ____________

Plan: 1. **NEXT VISIT:** __________
2. **Signature**____________________**MD/DO/NP/PA Date**:__________

10/03