

Sumana Ketha, MDPA

2925 Skyway Circle North, Irving, Texas 75038

Phone: (972) 675-7313, Fax: (972) 675-7310

Email: accounts@sumanakethamdpa.com

2024 Annual Wellness Form

The following information is being collected today as part of an Annual Wellness Visit. We understand that some of this information may have already been communicated to the doctor, but we would like to ensure that we keep your medical records up to date. If you have any questions, please let us know.

Patient Name

Date of Birth

Physician Name

Today's Date

SURGERIES/HOSPITALIZATION/INJURIES/TRANSFUSION

ALLERGIES/SEVERITY/REACTIONS

MEDICATIONS

List all medications including OTCs, vitamins/minerals, and dietary supplements including dosage, frequency, and route of administration

PATIENT NAME:

DOB:

DATE:

FAMILY HISTORY

	Father	Mother	Sibling(s)	Spouse	Grandparents	Other
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL HEALTH & HEALTH MANAGEMENT

In general, would you say your health is:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
In general, would you say your hearing is:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Please describe the current condition of your mouth and teeth (including false teeth or dentures)?	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
In the past 7 days, how much pain have you felt?	<input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> A lot
How confident are you that you can control and manage most of your health problems?	<input type="checkbox"/> I do not have any health problems <input type="checkbox"/> Confident. <input type="checkbox"/> Somewhat confident <input type="checkbox"/> Not Very Confident
Current physical activity as compared to last year is?	<input type="checkbox"/> More <input type="checkbox"/> Less <input type="checkbox"/> Same

VACCINATION & IMMUNIZATIONS

Did you receive Flu immunization?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Allergic _____ (Month / Day / Year)
When was your last Tetanus shot?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Allergic _____ (Month / Day / Year)
Have you ever had the Shingles Vaccination(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined
Have you ever had a Pneumonia Vaccination?	<input type="checkbox"/> Prevnar 13 _____ (Month/Day/Year) <input type="checkbox"/> Pneumovax 23 _____ (Month/Day/Year) <input type="checkbox"/> Yes, but I'm not sure of the type _____ (Month/Day/Year) <input type="checkbox"/> No

PATIENT NAME:

DOB:

DATE:

DIAGNOSTIC HISTORY

Please complete the following section with as much information as possible. Leave a section blank, if the section does not apply to you or if you do not remember the information.

Colonoscopy	_____ (Month / Day / Year)	_____ Physician	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Other Results <input type="checkbox"/> Not Applicable due to total Colectomy or colorectal cancer
Diabetic Eye Exam	_____ (Month / Day / Year)	_____ Physician / Clinic	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Results
Diabetic HbA1c	_____ (Month / Day / Year)	_____ HbA1c Level	
Eye Exam	_____ (Month / Day / Year)	_____ Physician / Clinic	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Results
Echocardiogram	_____ (Month / Day / Year)	_____ Physician	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Results
Dental Exam	_____ (Month / Day / Year)	_____ Physician	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Results
Bone Density	_____ (Month / Day / Year)	_____ Physician / Facility	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Results
Hepatitis C Testing	_____ (Month / Day / Year)	_____ Physician	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Results
Prostate Exam	_____ (Month / Day / Year)	_____ Physician	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Results
FEMALES ONLY			
Last Mammogram	_____ (Month / Day / Year)	_____ Physician / Facility	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Results <input type="checkbox"/> Not Applicable due to Bilateral mastectomy or 2 unilateral mastectomies
Pap Smear	_____ (Month / Day / Year)	_____ Physician	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Results

PATIENT NAME:

DOB:

DATE:

ADULT DEPRESSION SCREENING TOOL- PHQ-9 (If under the age of 18, please request an Adolescent screening tool)

In the Past 2 weeks:	Not at All	1 – 3 Days	Half the Days	Everyday
I have little interest or pleasure in doing things	0	1	2	3
I'm feeling down, depressed, or hopeless	0	1	2	3
I'm having trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
I'm feeling tired or have little energy	0	1	2	3
I haven't had an appetite or am overeating	0	1	2	3
I'm feeling bad about myself, I feel I've let my family or myself down	0	1	2	3
I have trouble concentrating on things such as reading the paper or watching TV	0	1	2	3
People have noticed that my speech slowed down or is rushed like I am restless	0	1	2	3
I have thoughts I would be better off dead or have thought about hurting myself in some way	0	1	2	3
(OFFICE USE ONLY) TOTALS	=	+	+	+
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people.	Not at All <input type="checkbox"/>	Somewhat Difficult <input type="checkbox"/>	Very Difficult <input type="checkbox"/>	Extremely Difficult <input type="checkbox"/>

TOBACCO / ALCOHOL/ OTHER ASSESSMENT

Do you currently use any form of tobacco products (including vape)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, how many years have you used tobacco products?	_____years
What form of tobacco do you use?	<input type="checkbox"/> Cigarette <input type="checkbox"/> Cigar <input type="checkbox"/> Chew <input type="checkbox"/> Pipe <input type="checkbox"/> E-Cig/Vape
How many per day?	_____amount of daily usage
If you do smoke, would you like to quit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many per week?	<input type="checkbox"/> 10 or more <input type="checkbox"/> 6-9 per week <input type="checkbox"/> 2-5 per week <input type="checkbox"/> I do not drink alcohol
Do you drink caffeine?	<input type="checkbox"/> Yes <input type="checkbox"/> No # servings a day _____
Do you use sunscreen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FALL RISK ASSESSMENT

During the last 12 months, have you fallen 2 or more times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
During the last 12 months, have you had a fall that resulted in an injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you think that you are at high risk for falling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use any assistive devices such as a walker, wheelchair or cane?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you having trouble with walking or balance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you require assistance getting up from a sitting position?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PATIENT NAME:

DOB:

DATE:

PAIN ASSESSMENT

Are you experiencing any pain? Pain Level (0-10): _____ Location and description of pain:
Please rate your pain on a scale of 0-10:
(0=No pain 10=unbearable)

Please list any medications that you take for pain: (over the counter or prescribed:

Cardiovascular and Cholesterol Medications

Are you taking ANY of the following medications Prasugrel (Effient), Aspirin, Clopidogrel (Plavix), Ticlopidine (Ticlid), Dipyridamole (Persantine), Ticagrelor (Brillinta)? Yes No

Are you taking a Statin Lipitor (atorvastatin), Zocor (Simvastatin), Crestor (Rosuvastatin), etc.? Yes No

ACTIVITIES OF DAILY LIVING

During the past 4 weeks, was someone available to help you if you needed and wanted help? No, Not at all Yes, Sometimes Yes, Always

In the past 4 weeks, have you had any trouble doing any of the following? If applicable, please list an individual who helped complete the task.

Take medications	<input type="checkbox"/> No difficulty <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, Require Assistance from
Getting around the home	<input type="checkbox"/> No difficulty <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, Require Assistance from
Bathing and Dressing	<input type="checkbox"/> No difficulty <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, Require Assistance from
Using the Telephone	<input type="checkbox"/> No difficulty <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, Require Assistance from
Traveling	<input type="checkbox"/> No difficulty <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, Require Assistance from
Grocery Shopping	<input type="checkbox"/> No difficulty <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, Require Assistance from
Preparing Meals	<input type="checkbox"/> No difficulty <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, Require Assistance from
Housework	<input type="checkbox"/> No difficulty <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, Require Assistance from
Managing Money	<input type="checkbox"/> No difficulty <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, Require Assistance from
Do you have a living will?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty driving your car?	<input type="checkbox"/> No, Difficulty <input type="checkbox"/> Yes, Sometimes <input type="checkbox"/> No, I do not drive
Do you always fasten your seat belt when in a vehicle?	<input type="checkbox"/> Yes <input type="checkbox"/> No
During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?	<input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Light <input type="checkbox"/> Very Light
Do you exercise for 20 minutes, 3 or more days a week?	<input type="checkbox"/> Yes, Most of the time <input type="checkbox"/> Yes, Some of the time <input type="checkbox"/> No, I do not exercise
Have you been given information to help you with the following:	
• Hazards in the home which may hurt you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Keeping track of your medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PATIENT NAME:

DOB:

DATE:

Please indicate any of the following Chronic Conditions that apply to you:

Chronic Condition	Date diagnosed	Managing Doctor	Date you last saw doctor	Today Physician Initials
Acquired Hypothyroidism				
Acute Myocardial Infarction				
Alzheimer's				
Senile Dementia				
Anemia				
Asthma				
Atrial Fibrillation				
Benign Prostatic Hyperplasia				
Cataract				
Chronic Kidney Disease				
COPD Chronic Obstructive Pulmonary Disease and Bronchiectasis				
Depression				
Diabetes				
Heart Failure				
Hip/Pelvic Fracture				
Hyperlipidemia				
Hypertension				
Ischemic Heart Disease				
Osteoporosis				
RA/OA (Rheumatoid Arthritis/ Osteoarthritis)				
Stroke / Transient Ischemic Attack				
Female/Male Breast Cancer				
Colorectal Cancer				
Prostate Cancer				
Lung Cancer				
Endometrial Cancer				

PATIENT NAME:

DOB:

DATE:

LIST OF PHYSICIANS
Optometrist
OB/GYN
Ophthalmologist
Cardiologist
Gastroenterologist
Nephrologist
Oncologist
Orthopedist
Pulmonologist
Rheumatologist
Urologist
Neurologist
Psychiatrist
Home Health Company
CPAP Company
Diabetes Supply Company
Other Supply Companies
Other

PATIENT NAME:

DOB:

DATE:

RECENT HOSPITALIZATIONS/INPATIENT, OUTPATIENT, EMERGENCY (In last 12 Months)		
DATE	FACILITY	REASON