Carolina Family Health Centers, Inc.

AWV Documentation

This form will be used to document the patient encounter when there is an electronic health record system failure.

Patient Name:	Date of Service:
DOB:	Provider:

VITALS

BP:	Pulse:	Respirations:	Pulse Ox:
Repeat BP:	Weight:	Height:	BMI:

TYPE OF AWV:

SCREENING QUESTIONS:
FUNCTIONAL ABILITY/SAFETY SCREEN

phone:
transportation:
shopping:
preparing meals:
housework:
laundry:
medication administration:
managing money:

Does your home have rugs in the hallway?
Do you have grab bars in the bathroom?
Do you have handrails on the stairs?
Does your home have poor lighting?
Have you fallen in the past 12 months?
Do you have trouble hearing?
Do you exercise three (3) or more times per week, for at least 30 minutes?
Do you eat five (5) servings of fruit and vegetables a day?
Are you or a family member concerned about your memory?
Do you feel overly tired or fatigued often?
Do you have any physical pain that limits your activities?
Have you had urinary or fecal incontinence in the past 6 months?
Do you have physical pain today?

MEDICATIONS:

VACCINATIONS:

PAST MEDICAL HISTORY(CHANGES?):

PAST SURGICAL HISTORY(CHANGES?):

MOST FORM:

PREVENTIVE PROCEDURES ORDERED:

EDUCATION PROVIDED: