MEDICARE WELLNESS VISIT

Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!

Name: ______________________ Date of Birth: ______________ Today's Date: ______________

Allergies / Intolerances

Type of Medication	Type of Reaction
Example Penicillin	*Rash*

____

____

____

____

____

History

Past Medical History

Please complete the following in as much detail as possible.

Diagnosis / Conditions *Please circle all that apply.*

Cardiovascular

Heart Disease	Heart Attack	Cardiac Catherization
Heart Valve Disorder	Atrial Fibrillation	Stent Placement/Angioplasty
High Blood Pressure	Defibrillator	Pacemaker Implantable
Elevated Cholesterol	Vascular Disease	Peripheral Arterial Disease
Palpitations	Blood Clotting Disorder	Deep Venous Thrombosis

Abdominal Aortic Aneurysm Screening (AAA Ultrasound) - Date of Last Exam: ___________

Other: ____

Endocrine

Diabetes (Type 2)	Diabetes (Type 1)	Osteoporosis (Weak bones)
Overactive Thyroid	Underactive Thyroid	

Fractures (please specify date and type): ____

Gastrointestinal

Heartburn / Reflux | Ulcer | Cirrhosis
Hepatitis A | Hepatitis B | Hepatitis C
Diverticulosis | Colon Polyps | Inflammatory Bowel Disease
Irritable Bowel | Constipation

Other: ____________________

Last Colonoscopy: Date of Exam: ____________________ Normal Abnormal Unknown

Hepatitis C Screening in the past? Yes No

Genitourinary

Urinary Tract Infections | Kidney Stones | Overactive Bladder/Incontinence
Kidney Cysts | Chronic Kidney Disease | Erectile Dysfunction
Enlarged Prostate | PSA Screen Date of Last Exam: ____________________

Are you sexually active? Yes No

Sexually Transmitted Infections: Chlamydia Gonorrhea Genital Herpes

Gynecological / Obstetrics

Cervical Cancer Screening (Pap) Date of Last Exam: ____________________

Dexa Date of Last Exam: ____________________

Mammogram Date of Last Exam: ____________________

Menstrual Period Date of Last: ____________________

Number of Pregnancies: __________ Number of Deliveries: __________

Neurologic / Psychiatric

Dementia | Stroke | Transient Ischemic Attack (TIA)
Parkinson's Disease | Depression | Post-Traumatic Stress Disorder
Neuropathy | Anxiety

Other: ____________________

Oncologic (Cancer) & Hematologic (Blood Disorders)

Please provide your diagnosis and check if disease is in remission or active.

Lung Cancer ____________________ Colon / Rectal Cancer ____________________
Breast Cancer ____________________ Prostate Cancer ____________________
Anemia ____________________ Other (Type) ____________________

Pulmonary

Asthma | COPD | Asbestos Exposure/Asbestosis
Emphysema | Pulmonary Nodules | Other: ____________________

Rheumatology / Joint Diseases	Cervical Disc Degeneration	Lumbar Disc Disease	Osteoarthritis
	Rheumatoid Arthritis	Gout	Other: _________________

Surgical History

Please provide dates in the space below.

	Year of Surgery		Year of Surgery
Appendix Removal		Hernia Repair	
Breast Biopsy / Surgery		Hysterectomy	
Cardiac Bypass		Ovarian Removal	
Carotid Artery Surgery		Other (type)	
Cataract Surgery		Other (type)	
Gallbladder Surgery		Other (type)	
Device Type & Date		Device Type & Date	

Hospitalizations

Please list all dates, reasons and complications for hospitalizations below.

Date of Hospitalization	Reason for Hospitalization	Complications

Family History

Family Member with a History of (Please define who had history and what age if applicable):

Abdominal Aortic Aneurysm		Diabetes Mellitus	
Breast Cancer		Mental Illness	
Colon Cancer		Ovarian Cancer	
Hypertension		Prostate Cancer	
Coronary Artery Disease		Stroke	
Other		Other	
Other		Other	

Social History

Please complete the following information. Please circle all that apply.

Advance Directives *Please bring a copy with you to your first appointmnet.*

DNR   Five Wishes   Guardian   Healthcare Surrogate

Living Will   Healthcare Power of Attorney   None

If none, would you like additional information explaining what these mean? Yes No

Tobacco Use

Never Smoked   Former Smoker   Current Smoker   Every Day   Some Days

How much do you or did you smoke? ______ Packs per Day Week

Do you currently use smokelss tobacco? Yes No Type: ____

Used smokelss tobacco in the past? Yes No Type: ____

Most Recent Tobacco or Smokeless Tobacco Use? _____/_______/_______ Number of Years Tobacco Used: ______

E-Cigarette / Vape Use: Current Former Never Used   Passive Smoke Exposure: Yes No

Are you interested in quitting? Yes No   Ready to Quit? Yes No

Alcohol / Drugs

Alcohol Intake: None Occasional Moderate Heavy

During the past 4 weeks, how many drinks of wine, beer, or other alcoholic beverages have you consumed? _________

Illicit / Recreational Drug Use: Never In Past Current Type: ___________________________________

General

Total Number in Household? _____ Are you currently employed? Yes No Occupational Exposures? Yes No

Current / Former Occupation: ____

Education: Less than 8th grade 8 9 10 11 12 2yr College 4yr College Post Graduate

Where are you from? ____

Do you have local family? Yes No   Number of Children: _______

Pets? Yes No   Able to care for self? Yes No

General Stress Level? Low Medium High   Caregiver: Family Friends Other None

Sexually Active? Yes No

Sexual Orientation: Heterosexual Homosexual Bisexual Decline to Answer

Caffeine Intake? None Occasional Moderate Heavy

Exercise? None Occasional Moderate Heavy

Type of Exercise: ____

Hobbies / Activities: ____

Diet: Regular Vegetarian Vegan Gluten Free Cardiac Diabetic Other: _______________

Smoke Alarm In Home? Yes No Seat Belts Used Regularly? Yes No

Sunscreen Used Routinely? Yes No

Domestic Violence? Yes No Religious / Spiritual Preference? ______________________________________

Medication Adherence

Do you understand all the medications as you are taking them? Yes No

Do you have any financial concerns related to the medication you are taking? Yes No

Do you have any other barriers related to the medications you are taking? Yes No

Communication Provisions

Do you have any communication barriers? None Cognitive Vision Language Hearing

Does the family / caregiver have any communication barriers? None Cognitive Vision Language Hearing

Medication Information

Note: Please bring ALL medications you are currently using (in their original containers) to your FIRST appointment.

Current Prescription Medications

This may include ointments, inhalers or any items for which you need a prescription, even if you use it rarely.

Name:	**Strength (Formulation)**	**Frequency**	Need refill in next 90 days?		
Example: Lisinopril	10mg (tablet)	Once Daily		Supply	Supply
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day
			No	90 day	30 day

Current Non-Prescription Medications

Name:	Strength (Formulation)	Frequency	Purpose
Example: Advil	200mg (capsule)	1 capsule every 6 hours	Headaches

Current Supplements

Name:	Strength (Formulation)	Frequency	Purpose

Pharmacy:

Name:	Location Address / Phone Number:

Mail Order Pharmacy (if different from local pharmacy):

Name:	Location Address / Phone Number:

Medical Supplies I Use

There are items for which you may need a prescription, such as diabetic shoes, oxygen, prosthetics, etc.

Name:	Purpose:
Example: Insulin Syringe	To take insulin for diabetes

Immunizations

Please indicate month, day and year last received.

Influenza Vaccine: ____________________

Pneumonia Vaccine: ____________________

Prevnar Vaccine: ____________________

Tetanus Booster: ____________________

TDAP: ____________________

Shingrix (Shingles) Vaccines: ____________________

Hepatitis A: ____________________

Hepatitis B: ____________________

Meningitis: ____________________

COVID-19 Vaccines & Booster: ____________________

Health Maintenance:

Last Colonoscopy: _______________

Last PSA: _______________

Date of Last Bone Density / DEXA Scan: _______________

Date of Last Mammogram: _______________

Date of Last Pap Smear: _______________

Date of Last Menstrual Period: _______________

Age at First Period: _______ Age at First Child _______ Age at Menopause _______

Number of Pregnancies: ______ Number of Living Children: _______

Current Birth Control Method: __________________________

Section A:

Alcohol and Drug Use:

Do you have more than 7 drinks per week? __________

Do you have more than 3 drinks per day? ________

If you answered yes to either of the above questions, please complete the AUDIT, DAST and CAGE screenings below. If you answered No to both questions above, please go to Section B.

AUDIT Screening:

How often did you have a drink containing alcohol in the past year?

Never   Monthly or Less   2-4 times a month

How many drinks did you have on a typical day when you were drinking in the past year?

1 or 2   3 or 4   5 or 6   7, 8 or 9   10 or more

How often did you have six or more drinks on one occasion in the past year?

Never   Less than Monthly   Monthly   Weekly   Daily or almost Daily

How often during the last year have you found that you were not able to stop drinking once you had started?

Never   Less than Monthly   Monthly   Weekly   Daily or almost Daily

How often during the last year have you failed to do what was normally expected from you because of drinking?

Never   Less than Monthly   Monthly   Weekly   Daily or almost Daily

How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never   Less than Monthly   Monthly   Weekly   Daily or almost Daily

How often during the last year have you had a feeling of guilt or remorse after drinking?

Never   Less than Monthly   Monthly   Weekly   Daily or almost Daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never   Less than Monthly   Monthly   Weekly   Daily or almost Daily

Have you, or has someone else, been injured as a result of your drinking?

No   Yes, but not in the last year   Yes, during the last year

Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?

No   Yes, but not in the last year   Yes, during the last year

Drug Use Questionaire (DAST) Screening:

Have you used drugs other than those required for medical reasons?	Yes	No
Do you abuse more than one drug at a time?	Yes	No
Are you unable to stop using drugs when you want to?	Yes	No
Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
Do you ever feel bad or guilty about your drug use?	Yes	No
Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
Have you neglected your family because of your use of drugs?	Yes	No
Have you engaged in illegal activities in order to obtain drugs?	Yes	No
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
Have you had medical problems as a result of your drug use (such as: memory loss, hepatitis, convulsions, or bleeding)?	Yes	No

Cage-AID Screening:

Have you felt you should CUT down on drinking or drug use?	Yes	No
Have others ANNOYED you by criticizing your drinking or drug use?	Yes	No
Have you felt bad or GUILTY about your drinking or drug use?	Yes	No
Have you ever had a drink or used drugs first thing in the morning (EYE-OPENER) to steady your nerves or get rid of a hangover?	Yes	No

Section B:

Lawton Instrumental Activities of Daily Living:

Bathing ability:	Don't Need Help	Need Some Assistance	Need Full Assistance
Dressing ability:	Don't Need Help	Need Some Assistance	Need Full Assistance
Using the Restroom:	Don't Need Help	Need Some Assistance	Need Full Assistance
Walking ability:	Don't Need Help	Need Some Assistance	Need Full Assistance
Do you leak urine?	Never	Sometimes	Frequently
Feeding ability:	Don't Need Help	Need Some Assistance	Need Full Assistance
Using the Telephone:	Don't Need Help	Need Some Assistance	Need Full Assistance
Shopping:	Don't Need Help	Need Some Assistance	Need Full Assistance
Food Preparation:	Don't Need Help	Need Some Assistance	Need Full Assistance
Housekeeping:	Don't Need Help	Need Some Assistance	Need Full Assistance

Laundry:	Don't Need Help	Need Some Assistance	Need Full Assistance
Transportation:	Don't Need Help	Need Some Assistance	Need Full Assistance
Medications:	Don't Need Help	Need Some Assistance	Need Full Assistance
Handling Finances:	Don't Need Help	Need Some Assistance	Need Full Assistance

Section C:

FIFE - Frailty Index for Elders

Do you need help getting in or out of bed? Yes No

Do you need help with washing or bathing? Yes No

Without wanting to, have you lost or gained 10 pounds the last 6 months? Yes No

Do you have tooth or mouth problems that make it hard to eat? Yes No

Do you have a poor appetite and quickly feel full when you eat? Yes No

Did your physical health or emotional problems interfere with your social activities? Yes No

Would you say your health is fair or poor? Yes No

Do you get tired easily? Yes No

Were you hospitalized in the last 3 months? Yes No

Did you visit an emergency room for a health problem in the past 3 months? Yes No

Fall Risk:

Did you have a fall in the past year? Yes No

How many times have you fallen in the past year? ______

Were you injured? Yes No NA

Do you feel unsteady when standing or walking? Yes No

Do you worry about falling? Yes No

Section D:

Advance Care Planning:

Do you have a Legally Authorized Representative (Healthcare Decision Maker)? Yes No

What legal document(s) do you have for your healthcare decisions:

Living Will HC Power of Attorney Five Wishes (See Bottom of Page 3)

Section E:

Social Determinants of Health:

Average Days of Moderate to Strenuous Exercise per Week: _____days

Minutes of Exercise per Session: ______ min

How hard is it for you to pay for the very basics like food, housing, and medical care?

Very hard Hard Somewhat hard Not very hard

In the past 12 months, was there a time when you were not able to pay the mortgage or rent on time? Yes No

In the past 12 months, how many places have you lived? ________

In the past 12 months, did you ever NOT have a steady place to sleep or slept in a shelter? Yes No

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications? Yes No

In the past 12 months, has lack of transportation kept you from meetings, work or from getting things needed for daily living? Yes No

In the past 12 months, were you worried bout running out of food? Never Sometimes Often

In the past 12 months, did you run out of food? Never Sometimes Often

Do you feel stress - tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time - these days?

Not at all Only a little To some extent Rather much Very much

In a typical week, how many times do you talk on the phone with family, friends or neighbors?

Never Once a week Twice a week Three times a week More than 3 times a week

How often do you get together with friends or relatives?

Never Once a week Twice a week Three times a week More than 3 times a week

How often do you attend church or religious services?

Never 1-4 times per year More than 4 times per year

Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic goups, or school groups? Yes No

How often do you attend meetings of the clubs or organizations you belong to?

Never 1-4 times per year More than 4 times per year

Are you: Married Widowed Divorced Separated Never married Living with a partner

Within the last year, have you been afraid of your partner or ex-partner? Yes No

In the last year, have you been humiliated or emotionally abused by your partner or ex-partner? Yes No

In the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?

Yes No

How often do you have a drink containing alcohol?

Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2 3 or 4 5 or 6 7 to 9 10 or more

How often do you have six or more drinks on one occasion?

Never Less than Monthly Monthly Weekly Daily or Almost Daily

Section F:

Care Team:

Please list all of your healthcare providers including specialists, oxygen, diabetic supplies, etc.:

Provider Name:	What do you see them for?

Section G:

ADDITIONAL QUESTIONS:

Do you ever drive after drinking, or ride with a driver who has been drinking? Yes No

Nutrition:

In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? _____

In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? ______

In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? ______

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day? _____

General Health:

In general, would you say your health is: Excellent Good Fair Poor

How would you describe the condition of your mouth and teeth—including false teeth or dentures?

Excellent Good Fair Poor

Sleep:

Each night, how many hours of sleep do you usually get? ____ hours

Do you snore or has anyone told you that you snore? Yes No

In the past 7 days, how often have you felt sleepy during the daytime? _____ days

Functional/Safety Assessment:

Do you have rugs in your home? Yes No

Do you have handrails or grab bars in your home? Yes No

Do you have good lighting in your home? Yes No

Do you have smoke detectors in your home? Yes No

Do you have a Carbon monoxide detector in your home? Yes No

Do you wear a seatbelt when you are in the car? Yes No

Do you have any firearms in the house? Yes No

In the past 7 days, how many days were you in pain? ______

In the past 7 days, what was your pain level on a scale of 1-10? _____