Medicare Wellness Visit

Name________________________________Date of Birth____________

Date of Exam____

How old are you?

Who is your primary care physician?

What are the names and specialties of other providers who care for you?

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

PERSONAL AND FAMILY MEDICAL HISTORY

	Heart Disease	High Blood Pressure	Diabetes	Hyperlipidemia	Thyroid Disease	Reflux	Liver Disease	Kidney Disease	Bleeding Disorder	Sickle Cell	Blood Clots	Stroke	Cancer	Dementia	Lung Disease	Surgery
Have you had?																
Mother?																
Father?																
Brother/Sister?																

Do you use tobacco products?	Yes	No	Don't Know
Do you use alcohol?	Yes	No	Don't Know
Do you have problems with your thinking or memory?	Yes	No	Don't Know
Do others say you have problems with your thinking or memory?	Yes	No	Don't Know
Over the last two weeks, have you felt down, depressed or hopeless?	Yes	No	Don't Know
Over the last two weeks have you felt little interest or pleasure in doing things?	Yes	No	Don't Know
Do you have trouble hearing the television or radio when others do not?	Yes	No	Don't Know
Do you have to strain or struggle to hear or understand conversations?	Yes	No	Don't Know
Have you fallen in the last 12 months?	Yes	No	Don't Know
Do you worry about falling?	Yes	No	Don't Know

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Name____Date of Birth_______________________

Social History and Home Environment

Education_______________________
Occupation______________________
Marital Status____________________
Home Environment: ☐ Private Home ☐Assisted Living ☐ Other____________________

Do you need help with preparing meals, transportation, shopping, taking medicine or managing your finances?	Yes	No	Don't Know
Does your home have grab bars in bathrooms and handrails on the stairs or steps?	Yes	No	Don't Know
Does your home have functioning smoke alarms?	Yes	No	Don't Know

Have you had:

Bone density testing	Yes	No	Don't Know	Date:
Lipid levels	Yes	No	Don't Know	Date:
Colorectal cancer testing (colonoscopy)	Yes	No	Don't Know	Date:
Diabetes test	Yes	No	Don't Know	Date:
Diabetes self-management training	Yes	No	Don't Know	Date:
Glaucoma test	Yes	No	Don't Know	Date:
Prostate cancer test	Yes	No	Don't Know	Date:
Mammography	Yes	No	Don't Know	Date:
Pneumonia vaccine	Yes	No	Don't Know	Date:
Influenza vaccine	Yes	No	Don't Know	Date:
Hepatitis B vaccine	Yes	No	Don't Know	Date:
Tetanus vaccine	Yes	No	Don't Know	Date:
Pertussis vaccine	Yes	No	Don't Know	Date: