Medicare Wellness Visit (female form)

Patient's name: _____ D.O. B_____/_____/_____ Exam Date: _____

Primary Care Provider:_____

Allergies & Reactions: _____

	Never	Former	Current	If yes, how much per day?	How many years of Tobacco Use?
Tobacco Use-Smoking					
Tobacco Use-Chewing					
Alcohol Use					
Drug Use					

Current list of providers/specialists and suppliers

Name	Specialty	Reason

Family History: Particularly Parents, Grandparents, Siblings (check those that apply)

Condition:	X	Relative:
Alcoholism		
Arthritis		
Cancer		
Diabetes		
Heart Disease		
High Cholesterol		
High Blood Pressure		
Liver or Kidney Disease		
Obesity		
Stroke		
Thyroid Disease		
OTHER:		

Immunizations: Please give dates and locations of Immunizations/Vaccines:

VACCINE:	DATE:	FACILITY:
Tetanus		
Pneumonia (Pneumovax 23, Prevnar 13)		
Shingles (Zostavax)		
Flu (Influenza)		

Surgical History: List any surgeries you have had performed:

SURGERY:	PROVIDER/FACILITY:	DATE:

Screens/Tests: Please give dates and locations of Screens/Testing

TEST:	PROVIDER/FACILITY:	DATE LAST DONE:
Colonoscopy		
Eye Test for Glaucoma		
Pap Test		
Mammogram		
Lab: Cholesterol Panel		
Lab: Glucose		

If you are Diabetic:		
Retinal Eye Exam		
Urine Microalbumin		
Lab: Hemoglobin A1c		

How would you rate your overall health? **Poor Fair Good Very Good Excellent**

Are you on a Special Diet? **YES NO** If "Yes", what type?

How many times/week do you exercise? _____ Duration? _____ Type? _____

Circle any Assistive Devices you use: **Glasses Contacts Hearing Aides Cane Walker Wheel chair Dentures Upper Dentures Lower**

Memory:

1. Do you have trouble remembering what month or day it is? **YES NO**
2. Do you have trouble remembering appointments? **YES NO**

Hearing loss screen

1. Do you have trouble hearing the TV or radio when others don't? **YES NO**
2. Do you have to strain or struggle to hear/understand conversations? **YES NO**

Function screen

1. Do you need help with preparing meals, housekeeping, transportation, shopping, taking your meds, managing finances, or other activities of daily living? **YES NO**
2. Do you need help with dressing, bathing, or walking? **YES NO**
3. Do you live alone? **YES NO**

Fall Screen

1. Have you had more than one fall in the last year? **YES NO**
2. Have you had an injury from a fall in the last year? **YES NO**

Home safety screen

1. Does your home have rugs, poor lighting, or a slippery bathtub/shower? **YES NO**
2. Does your home have grab bars in bathrooms, handrails on stairs or steps? **YES NO**
3. Does your home have functioning smoke alarms? **YES NO**

Do you have an Advanced Care Plan such as a Living Will or POST? YES NO

If "no", would you like to discuss a plan today? **YES NO**

Advanced Care Planning Consent: "I consent to discuss end-of-life issues with my healthcare provider."

_____ _____

Patient/Guardian Signature Date