Premier Patient Health Care™

MEDICARE WELLNESS VISIT
MEDICAL & HEALTH HISTORY

**(To be completed by the patient, family member, or caregiver prior to seeing the doctor)

*** ACO Required**

*** Please Note: This form is replaced by Annual Past Medical history after year one. Allergy/medication and Patient checklist forms must be completed at initial and Annual

Name: _____ Date of Birth _____ Date of Appointment_____

CHRONIC Medical Problem	Date of Onset	Complications

Lifestyle History:

Do you wear seatbelts? _____Yes ____ No ____ Sometimes

Do you wear sunscreen? _____Yes ____ No ____ Sometimes

Does your home have working smoke detectors? ____ Yes ____No

Does your home have working carbon monoxide detectors? ____ Yes ____No

Do you have a living will/advanced directives? ____ Yes ____No

Have you been given any information to help you with the following?

Hazards in your house that might hurt you? _____ Yes _____No

Keeping track of your medications? _____ Yes _____No

Family History (check or enter "x" if a condition applies to that relative)

	Heart Disease	High Blood Pressure	Diabetes	Cancer (type)	Other Write In
Father		☐	☐		
Mother		☐	☐		
Brothers		☐	☐		
Sisters		☐	☐		
Children		☐	☐		

List of All of Your Doctors

Physician Name	Specialty

PLEASE CONTINUE TO THE NEXT PAGE

Premier Patient Health Care™

MEDICARE ANNUAL WELLNESS VISIT

PATIENT CHECKLIST

****(To be completed by the patient, family member, or caregiver prior to seeing the doctor)**

*1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, or sad? **Check one (place "x"):**

Not at all	Slightly	Moderately	Quite a bit	Extremely

*2. During the past 4 weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups? **Check one (place "x")**

Not at all	Slightly	Moderately	Quite a bit	Extremely

***(physician: Administer PHQ-9 if answer is in shaded area for 1 or 2)**

*3. During the last 12 months, have you fallen more than 2 times?

Yes	No

*4. During the last 12 months, have you had a fall that resulted in an injury?

Yes	No

*5. Do you think that you are at high risk for falling?

Yes	No

***(physician: Administer fall risk assessment if answer is "yes" for 3, 4, or 5)**

*6. Do you smoke or use tobacco products? **Circle one**

No, I have never smoked/used tobacco	**No, I am a former smoker/tobacco user**
Yes, I smoke/use tobacco and want to quit	**Yes, I smoke/use tobacco and do not want to quit**

(physician: provide cessation counseling if the answer is "yes")

7. In the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have? **Check one**

10 or more per week	**6-9 per week**	**2-5 per week**	**1 drink or less per week**	**none**

8. During the past 4 weeks, the hardest physical activity you could do for at least 2 minutes was? **Check one**

Very Heavy	**Heavy**	**Moderate**	**Light**	**Very light**

9. Do you exercise at least 20 minutes, 3 or more days per week? **Check one (enter "x")**

Yes, most of the time	**Yes, some of the time**	**No, I do not exercise this much**

10. During the past 4 weeks, how would you rate your health? **Check one (enter "x")**

Excellent	**Very Good**	**Good**	**Fair**	**Poor**

11. During the past 4 weeks, how much bodily pain have you had? **Check one (enter "x")**

No Pain	**Very Mild Pain**	**Mild Pain**	**Moderate Pain**	**Severe Pain**

PLEASE CONTINUE TO NEXT PAGE

12. How often <u>in the past 4 weeks</u> have you been bothered by any of the following problems?

	Never	Seldom	Often	Always
Fall or dizzy when standing up	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐
Difficulty eating well	☐	☐	☐	☐
Teeth or Dentures	☐	☐	☐	☐
Problems using the telephone	☐	☐	☐	☐
Tired or Fatigued	☐	☐	☐	☐

13. How often do you have trouble taking medicines the way that you have been told to take them? **Check one**

I do not have to take medicine	**I always take them as prescribed**	**I sometimes take them as prescribed**	**I seldom take them as prescribed**

14. How confident are you that you can control and manage most of your health problems?

Very confident	**Somewhat confident**	**Not very confident**	**I do not have health problems**

15. Are you having difficulties driving your car?

Yes, often	**Sometimes**	**No**	**I do not drive**

16. During the past 4 weeks, was someone available to help you **if** you needed and wanted help?

Yes, as much as I wanted	**Yes, quite a bit**	**Yes, some**	**Yes, a little**	**No, not at all**

17. Can you do the following without help?

	Yes	No
Travel alone by bus, taxi, or drive your own car?	☐	☐
Shop for groceries or clothing without help?	☐	☐
Prepare your own meals?	☐	☐
Do your own housework without help?	☐	☐
Eating, bathing, dressing, or getting around your home	☐	☐

I have reviewed the above information provided to me by the patient.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

Other notes/observations: