



**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

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



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

Yes	No
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*5. Do you think that you are at high risk for falling?

Yes	No
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***(physician: Administer fall risk assessment if answer is "yes" for 3, 4, or 5)**

*6. Do you smoke or use tobacco products? **Check one (enter "x")**

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

Excellent	Very Good	Good	Fair	Poor
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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
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12. How often in the past 4 weeks 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
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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
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15. Are you having difficulties driving your car?

Yes, often	Sometimes	No	I do not drive
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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
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17. Can you do the following without help?

Yes

No

	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:

