Patient Name_____Date_____Provider_____

Medicare Wellness Visit Patient Intake

Note: Please complete all sections before seeing your provider.

List any hospitalizations, major illness or visits to the emergency room since last year or last visit:

Date	Reason	Location

Medical History

Personal and Family Medical History ☐ No changes since last year/visit						
	Me	Father	Mother	Siblings	Children	Specify Disease
Coronary Disease						
High Blood Pressure						
High Cholesterol						
Cerebral Vascular Disease/Stroke						
Renal Disease						
Cancer						
Diabetes						
Aortic Aneurysm						

Past Surgeries	Date	Past Surgeries	Date

Names of All Providers/Specialists You See

Doctor's Name	Specialty Type and Reason You See Them

List of Medical Equipment/Service Providers

Supply	Who provides this service for you?
Oxygen/CPAP	
Diabetic Supplies	
Home Health	
Other	

Patient Name_____Date_____Provider_____

Changes in medications or allergies since last year or last visit: ☐ No changes since last year/visit

New patients may document additional medications on the back of this form.

Medication	Dose	Reason for Taking

Allergies	Reaction	Allergies	Reaction

Medications: What pharmacy fills your prescriptions? _____

Are you having trouble taking your medications as prescribed? Yes ☐ No ☐

Are you interested in having your prescriptions sent to your home? Yes ☐ No ☐

Accident Prevention

Do you wear seatbelts in the car? ☐ Yes ☐ No ☐ I prefer not to answer

Do you have smoke detectors at home? ☐ Yes ☐ No ☐ I prefer not to answer

Do you have carbon monoxide detectors? ☐ Yes ☐ No ☐ I prefer not to answer

Do you have firearm(s) at home? ☐ Yes ☐ No ☐ I prefer not to answer

If you do have firearm(s), are they locked up? ☐ Yes ☐ No ☐ I prefer not to answer

Activities of Daily Living

Do you require assistance with any of the following activities?

Using the telephone	☐ Yes ☐ No	Eating	☐ Yes ☐ No
Shopping	☐ Yes ☐ No	Getting from bed to chair	☐ Yes ☐ No
Meal preparation	☐ Yes ☐ No	Dressing	☐ Yes ☐ No
Housekeeping	☐ Yes ☐ No	Bathing	☐ Yes ☐ No
Laundry	☐ Yes ☐ No	Toileting	☐ Yes ☐ No
Driving/taking taxi or bus	☐ Yes ☐ No	Continence	☐ Yes ☐ No
Taking medications	☐ Yes ☐ No		
Handling finances	☐ Yes ☐ No		

I have someone available to help if needed (for a sick day) ☐ Yes, any time ☐ Yes, sometimes ☐ Not really

Personal concern about your memory – or family mentions concern ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No ☐ I no longer drink alcohol

If yes, how many times in the last year have you had more than 5 drinks (male) or 4 drinks (female) in one day? ____ ☐ I'm interested in talking more about my alcohol use

Patient Name_____Date_____Provider_____

Have you ever smoked or chewed tobacco or smoked marijuana? ☐ No ☐ Yes ☐ Current: _____ per day

☐ I'm interested in help to stop using _____

Do you use illicit drugs? ☐ No ☐ Yes ☐ I'm interested in help to stop using _____

Diet: ☐ balanced ☐ vegetarian ☐ diabetic ☐ low salt ☐ low fat ☐ low carb ☐ other: _____

Do you exercise every day? ☐ No ☐ Yes If not daily, how often? _____

Have you had any falls in the past year? ☐ No ☐ Yes If yes, any injuries: _____

I use a: ☐ cane ☐ walker ☐ wheelchair ☐ other: _____

In the last two weeks check (√) how often have you been bothered by the following:	**Not at all (0)**	**Several days (1)**	**More than half the days (2)**	**Nearly every day (3)**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed; or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Add columns for total score:				

If you checked *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Health Screenings

Do you have trouble hearing? ☐ Yes ☐ No Do you wear a hearing aid? ☐ Yes ☐ No

Last hearing exam: _____

Patient Name_____Date_____Provider_____

Do you have trouble seeing? ☐ Yes ☐ No Do you wear glasses or contacts? ☐ Yes ☐ No

Most recent diabetic retina (dilated) eye exam: ☐ I'm not a diabetic

- Mo/Yr _____/_____
- By Dr. _____ Ophthalmologist/Optometrist (please circle one)
- Location (name of eye doctor's office, if known) _____
- Result of retina exam _____ (e.g., negative for retinopathy)

When was your most recent:

Mammogram: Mo/Yr: _____Where: _____Result: _____

Colonoscopy: Mo/Yr: _____Where: _____ Result: _____

I elected another colon test: ☐ FIT-DNA Yr.:_____ Result: _____

☐ FOBT Yr.:_____ Result: _____

☐ Other colon screening: _____ Yr.:_____Result: _____

Osteoporosis Screening (DEXA) bone scan:

Mo/Yr: _____/_____ Location: _____ (name of imaging center)

☐ I received my bone scan in my home

I have a: ☐ Living will ☐ Medical Order for Life Sustaining Treatment (MOST)

☐ Medical Power of Attorney ☐ Other: _____

☐ I'm interested in learning more about documenting my wishes for end of life decision-making

I'd like to talk with a care coordinator about _____.

A care coordinator can assist with managing chronic diseases like diabetes, heart failure and COPD. They can help find options for: reducing cost of medications, transportation, long-term care planning, caregiver support, end of life decision-making, resources for mental health or substance abuse.