Patient Name: ________________________ Date__________ Provider____________________

Medicare Wellness Visit Patient Intake

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

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

Office Use: Med list reconciled ________

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 Aneurysms						

Office Use: PMH updated ________

Past Surgeries	Date	Past Surgeries	Date

Office Use: Surgical hx updated ________

Names of All Providers / Specialists You See:

Doctor's Name	Specialty Type and Reason You See Them

Patient Name: ________________________ Date__________ Provider____________________

List of Medical Equipment/Service Providers

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

Activities of Daily Living

Do you require assistance with any of the following activities?

Using the telephone ☐ yes ☐ no
Shopping ☐ yes ☐ no
Meal preparation ☐ yes ☐ no
Housekeeping ☐ yes ☐ no
Laundry ☐ yes ☐ no
Driving/taking taxi or bus ☐ yes ☐ no
Taking medications ☐ yes ☐ no
Handling finances ☐ yes ☐ no

Eating ☐ yes ☐ no
Getting from bed to chair ☐ yes ☐ no
Dressing ☐ yes ☐ no
Bathing ☐ yes ☐ no
Toileting ☐ yes ☐ no
Continence ☐ yes ☐ no

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

Accident Prevention:

Do you wear seatbelts in the car? ☐ yes ☐ no
Do you have smoke detectors at home? ☐ yes ☐ no
Do you have carbon monoxide detectors? ☐ yes ☐ no
Do you have a firearm at home? ☐ yes ☐ no If yes, is it locked up? ☐ yes ☐ no

Health Screening: Substance Use, Diet, Exercise, Fall Risk

Do you drink alcohol? ☐ no ☐ yes ______ drinks per day / week (circle one) ☐ I no longer drink alcohol
Have you ever smoked or chewed tobacco? ☐ no ☐ yes ☐ currently use how much: _________ per day
Do you use marijuana or 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, how often do you exercise? _________________________
Have you had any falls in the past year? ☐ no ☐ yes If yes, any injuries: ____________________________

Do you have trouble hearing? ☐ yes ☐ no
Do you wear a hearing aid? ☐ yes ☐ no
Last hearing exam: _______________

Do you have trouble seeing? ☐ yes ☐ no
Do you wear glasses or contacts? ☐ yes ☐ no
Last eye exam by optometrist or ophthalmologist: _____________

Office Use: Referral ☐ PHP Care Coordinator Referral ☐

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Patient Name: ______________________________ **Date:** ______________________

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)	**Not at all** Each ✓ = 0	**Several days** Each ✓ = 1	**More than half the days** Each ✓ = 2	**Nearly every day** Each ✓ = 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:				

10. If you checked off <u>any</u> problems, how <u>difficult</u> 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	Slightly difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Jane B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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Patient Name: ________________________ Date__________ Provider____________________

I have a: ☐ Living will ☐ Medical Order for Life Sustaining Treatment ☐ Medical Power of Attorney

☐ Other: ______________________

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

Office: PHP Care Coordinator Referral ☐ *and schedule visit* ☐

Form provided, noted _____

Patient Signature: ____

Date:____