Name: ____________________________Date of birth_____________________ Today's date_______________

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 visit

Date	Reason	Location

Changes in medications or allergies since last visit ☐ **No changes since last visit**

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

Medication	Dose	Reason for Taking

Allergies	Reaction	Allergies	Reaction

Medical History ☐ **No changes since last visit**

Personal and Family Medical History ☐ No changes since last 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						

Surgeries Since Last Visit	Date	Past Surgeries	Date

Names of any new providers/specialists you have seen since last visit:

Provider's Name	Specialty Type and Reason You See Them

Name: ____________________________Date of birth_____________________ Today's date_______________

List of new 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 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

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 gun at home? ☐ yes ☐ no If yes, is it secured? ☐ 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 ☐ I 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 have trouble seeing? ☐ yes ☐ no
Do you wear a hearing aid? ☐ yes ☐ no Do you wear glasses or contacts? ☐ yes ☐ no
Last hearing exam: _______________ Last eye exam by optometrist or ophthalmologist: _____________
Personal concern about memory or family mentions concern ☐ yes ☐ no

Name: ____________________________Date of birth_____________________ Today's date_______________

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**

Depression Screening:

In the last two weeks, ✓ how often have you been bothered by the following:	Not at all	Several days	More than half the days	Nearly every day
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				

If you checked off *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
☐	☐	☐	☐

Patient Signature: ____

For Office Use Only

Cognition screen prompts Mini-Cog
Three word registration score: _____
Clock drawing score: _____
Three word recall score: _____

Mini-Cog Score, note documented in EMR: ☐