Medicare Wellness & Preventative Physical Exam

Patient Name: _____ DOB: _____

Today's Date: _____

Social History
Tobacco [ ] current user Type: Freq: [ ] 2nd hand [ ] Never [ ] Prior use Quit Date:
Alcohol [ ] Never [ ] Occasional [ ] Daily
Drug Abuse [ ] Never [ ] Occasional [ ] Daily [ ] Prior Use Quit Date:
Occupation: Exercise type/ frequency:
Home environment [ ] Private Home [ ] Assisted Living [ ] Other: (describe)

Family History (Use X to indicate positive history)									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart Disease									
Stroke									
Kidney Disease									
Obesity									
Genetic Disorder									
Liver Disease									
Depression or manic depressive disorder									
Colon/ Rectal cancer									
Breast cancer									
Other Cancer									
Other: _____									

Medical History				
Hospital visits since last office visit/ reason	Facility	Attending physician	Date of hospital visit	Past surgeries (include date & description of complications

Allergy List [ ] updated, located in patients EHR log

Medication List [ ] updated, located in patients EHR log

Other Physicians & Providers of Care		
Name & specialty/ provider type	Type of care	Date discontinued

Physician/ Provider acknowledgement of review_____

Patient Name: _____ DOB: _____

Health Risk Assessment

How do you rate your overall health? *(Excellent, Very Good, Good, Fair, Poor)*

Please indicate how many days a week do you perform the following:

_____ 1. Engage in physical activity for at least 20-30 minutes:

_____ 2. Include strength exercises in physical activity routine:

_____ 3. Eat 5 or more servings of fruits and vegetables:

_____ 4. Eat 5 or more servings of grains:

_____ 5. Eat 2 or more servings of dairy products:

_____ 6. Eat Fast Food:

_____ 7. Cut the size of meals or skip meals because there's not enough food, money, or help to shop or cook:

_____ 8. Have more than 1 drink of alcohol:

_____ 9. Get at least 7 hours of sleep:

_____ 10. Use tobacco or nicotine products or are close to others who do:

_____ 11. Leave home to run errands, go to work, meetings, classes, church, and social functions:

_____ 12. Have physical pain that affects your activities:

Please indicate Yes or No to the following questions:

Yes	No	
		Do you visit your dentist for regular dental checkups every 6 months for natural teeth or once a year for full dentures?
		Do you have enough money to pay for medications, medical supplies, and medical visits?
		In the past 30 days, have you missed taking your medications, if so how many times?
		In the past 30 days, have you taken your medications differently than prescribed by your doctor?
		Do you take any over-the-counter medications (vitamins, supplements, herbal medicines)?
		Do you have sufficient and reliable transportation to make it to all of your medical appointments?
		In the past year, have you had any problems with balance, walking, or have you had any falls? How many?
		In the past 6 months, have you had any problems with leakage of urine?
		In the past month, have you needed help managing your finances?
		Do you think anybody is taking or using your money without permission?
		In the past 7 days, have you needed help from others to do any of the following: a. To eat, bathe, get dressed, or use the toilet? c. For transportation? b. Do laundry, cook, housekeeping, or go shopping? d. To take your medicines?
		Do you or your caregiver have sufficient help/ support with resources for caregiving duties?
		Are you satisfied with your current level of social interaction with family and friends, and participation in activities outside of your home?
		Do you have family and friends who care about you and that you can count on for help when you need something or have a problem?
		Is anybody mistreating you?
		In your home, do you have any of the following: a. Rugs in hallways b. Grab bars installed in your bathroom c. Handrails on the stairs? d. Good lighting in all rooms and hallways
		Do you have an Advance Directive or Living Will?