DATE: ______/______/______
☐ HG ☐ SY ☐ EH ☐ CQ ☐ RL ☐ AS

☐ **G0402** IPPE "WELCOME TO MEDICARE" (1ST 12 Months MCR)
☐ **G0438** PPPS ANNUAL WELLNESS - FIRST VISIT (66+ YRS)
☐ **G0439** PPPS ANNUAL WELLNESS"- SUBSEQUENT VISIT

# ANNUAL WELLNESS VISIT (MEDICARE ONLY)

| **Name** *(Last, First, M.I.)*: ☐ M ☐ F | **DOB:** ______/______/______ |
|---|---|
| **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed | |
| **Previous or referring doctor:** | **Date of last physical exam:** ______/______/______ |
| | |
| **Height:** __________ inches **Weight:** __________ lbs **BMI:** __________ **Blood Pressure:** _______ /_______ mmHG | |

## HEALTH HISTORY QUESTIONNAIRE

### PERSONAL HEALTH HISTORY

| **Childhood illness:** | ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio | |
|---|---|---|
| **Immunizations and dates:** | ☐ Tetanus ______/______/______ | ☐ Pneumonia ______/______/______ |
| | ☐ Hepatitis ______/______/______ | ☐ Chickenpox ______/______/______ |
| | ☐ Influenza ______/______/______ | ☐ MMR *Measles, Mumps, Rubella* ______/______/______ |
| **Preventive Services:** | ☐ Mammogram _____/_____/_____ ☐ Bone Density _____/_____/_____ | ☐ Colonoscopy _____/_____/_____ |

| **Medical History – Specify any current medical problems you have or that other doctors have diagnosed** | | | | | |
|---|---|---|---|---|---|
| Heart disease: | ______/______/______ | High blood pressure | ______/______/______ | High cholesterol | ______/______/______ |
| *- type of heart disease* | ___________________ | Diabetes | ______/______/______ | Thyroid problem | ______/______/______ |
| Asthma/lung disease | ______/______/______ | Cancer: | ______/______/______ | Other: | ______/______/______ |
| Depression | ______/______/______ | *- type of cancer* | ___________________ | *- specify medical problem* | ___________________ |

| **Surgeries – list all prior hospital stays, operations, injuries and treatments, etc.** | | |
|---|---|---|
| Year | Reason | Hospital |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Other physicians, providers, hospitalizations and suppliers regularly involved in providing you with medical care.** | | |
|---|---|---|
| Provider | Reason | Hospital/Facility/Medical Supply Company |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Have you ever had a blood transfusion?** | ☐ Yes | ☐ No |
|---|---|---|

## PERSONAL HEALTH HISTORY

| List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers | | |
|---|---|---|
| Name the Drug | Strength | Frequency Taken |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Allergies to medications | |
|---|---|
| Name the Drug | Reaction You Had |
| | |
| | |
| | |

## HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

| | | | | | |
|---|---|---|---|---|---|
| **Exercise** | ☐ Sedentary (No exercise) | | | | |
| | ☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf) | | | | |
| | ☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) | | | | |
| | ☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes) | | | | |
| **Diet** | Are you dieting? | | | ☐ Yes | ☐ No |
| | If yes, are you on a physician prescribed medical diet? | | | ☐ Yes | ☐ No |
| | # of meals you eat in an average day? | | | | |
| | Rank salt intake | ☐ Hi | ☐ Med | ☐ Low | |
| | Rank fat intake | ☐ Hi | ☐ Med | ☐ Low | |
| **Caffeine** | ☐ None | ☐ Coffee | ☐ Tea | ☐ Cola | |
| | # of cups/cans per day? | | | | |
| **Alcohol** | Do you drink alcohol? | | | ☐ Yes | ☐ No |
| | If yes, what kind? | | | | |
| | How many drinks per week? | | | | |
| | Are you concerned about the amount you drink? | | | ☐ Yes | ☐ No |
| | Have you considered stopping? | | | ☐ Yes | ☐ No |
| | Have you ever experienced blackouts? | | | ☐ Yes | ☐ No |
| | Are you prone to "binge" drinking? | | | ☐ Yes | ☐ No |
| | Do you drive after drinking? | | | ☐ Yes | ☐ No |
| **Tobacco** | Do you use tobacco? | | | ☐ Yes | ☐ No |
| | ☐ Cigarettes – pks./day | | ☐ Chew - #/day | ☐ Pipe - #/day | ☐ Cigars - #/day |
| | ☐ # of years | ☐ Or year quit | | | |

## HEALTH HABITS AND PERSONAL SAFETY

Please put a check mark to indicate your answer.

| | | | |
|---|---|---|---|
| **Drugs** | Do you currently use recreational or street drugs? | ☐ Yes | ☐ No |
| | Have you ever given yourself street drugs with a needle? | ☐ Yes | ☐ No |
| **Sex** | Are you sexually active? | ☐ Yes | ☐ No |
| | If yes, are you trying for a pregnancy? | ☐ Yes | ☐ No |
| | If not trying for a pregnancy list contraceptive or barrier method used: | | |
| | Any discomfort with intercourse? | ☐ Yes | ☐ No |
| | Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? | ☐ Yes | ☐ No |
| **Personal Safety** | Do you live alone? | ☐ Yes | ☐ No |
| | Do you have frequent falls? | ☐ Yes | ☐ No |
| | Do you have vision loss? | ☐ Yes | ☐ No |
| | Do you have hearing loss? | ☐ Yes | ☐ No |
| | Physical and/or mental abuses have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? | ☐ Yes | ☐ No |
| **Any Other Recent Changes?** | Weight | ☐ Yes | ☐ No |
| | Energy Level | ☐ Yes | ☐ No |
| | Ability to sleep | ☐ Yes | ☐ No |
| | Other pain/discomfort | ☐ Yes | ☐ No |
| **Advanced Directive** | Do you have a Living Will, also known as Instruction Directive? | ☐ Yes | ☐ No |
| | Do you have a Power of Attorney (POA), also known as Proxy Directive? Please specify POA ____________________________________________ | ☐ Yes | ☐ No |
| | Do you have a Do Not Resuscitate (DNR) directive? | ☐ Yes | ☐ No |
| | Would you like information on the preparation of these? If so, please specify. | ☐ Yes | ☐ No |

## MENTAL HEALTH

Over the last two weeks, how often have you been bothered by the following problems. Please put a check mark to indicate your answer.

| | Not at all | Several days | More than half days | Nearly everyday |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself – or that you are a failure of have let yourself or your family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things (such as reading a newspaper or watching television) | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restlessness that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| Thoughts that you would be better off dead or hurting yourself in some way | 0 | 1 | 2 | 3 |
| **FOR OFFICE CODING:** | 0 + | ____________ + | _____________ + | ____________ |
| **TOTAL SCORE:** | ____________ | | | |
| If you've checked off any problems above, 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 ☐ |

| FAMILY HEALTH HISTORY | | | | | |
|---|---|---|---|---|---|
| Please put a check mark to specify any family member(s) with the following conditions, including age. | | | | | |
| | Father | Mother | Sibling | Children | Specify Other Relative |
| Alcoholism | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ _________________ at age ____ |
| Asthma/COPD | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ _________________ at age ____ |
| Bleeding/clotting disorder | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ _________________ at age ____ |
| Cancer (*specify type*) | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ _________________ at age ____ |
| Depression/suicide | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ _________________ at age ____ |
| Diabetes | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ _________________ at age ____ |
| Glaucoma | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ _________________ at age ____ |
| Heart disease (*specify type*) | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ _________________ at age ____ |
| High blood pressure | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ _________________ at age ____ |
| High cholesterol | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ _________________ at age ____ |
| Stroke | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ at age ____ | ☐ _________________ at age ____ |
| Other (*specify*): ______________________________________________ | | | | | |

| SOCIAL AND CULTURAL CHARACTERISTICS |
|---|
| Please put a check mark to indicate your answer. |
| |
| Do you live....<br>☐ Alone in the house ☐ w/ children ☐ w/ grandchildren ☐ w/primary caregiver, full-time ☐ w/ primary caregiver, part-time ☐ w/ animals |
| Do you require assistance moving around the house? ☐ Yes - please specify: ______________________________<br>☐ No |
| Have you been receiving late payment invoices, bounced checks and calls from bill collectors? ☐ Yes ☐ No |
| Are you accumulating stacks of unopened mails or have an overflowing mailbox? ☐ Yes ☐ No |
| Are you missing important appointments? ☐ Yes ☐ No |

## WOMEN ONLY

| | | |
|---|---|---|
| Age at onset of menstruation: | | |
| Date of last menstruation: | | |
| Period every ______ days | | |
| Heavy periods, irregularity, spotting, pain, or discharge? | ☐ Yes | ☐ No |
| Number of pregnancies ______ Number of live births ______ | | |
| Are you pregnant or breastfeeding? | ☐ Yes | ☐ No |
| Have you had a D&C, hysterectomy, or Cesarean? | ☐ Yes | ☐ No |
| Any urinary tract, bladder, or kidney infections within the last year? | ☐ Yes | ☐ No |
| Any blood in your urine? | ☐ Yes | ☐ No |
| Any problems with control of urination? | ☐ Yes | ☐ No |
| Any hot flashes or sweating at night? | ☐ Yes | ☐ No |
| Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? | ☐ Yes | ☐ No |
| Experienced any recent breast tenderness, lumps, or nipple discharge? | ☐ Yes | ☐ No |
| Date of last pap and rectal exam? | | |

## MEN ONLY

| | | |
|---|---|---|
| Do you usually get up to urinate during the night? | ☐ Yes | ☐ No |
| If yes, # of times ______ | | |
| Do you feel pain or burning with urination? | ☐ Yes | ☐ No |
| Any blood in your urine? | ☐ Yes | ☐ No |
| Do you feel burning discharge from penis? | ☐ Yes | ☐ No |
| Has the force of your urination decreased? | ☐ Yes | ☐ No |
| Have you had any kidney, bladder, or prostate infections within the last 12 months? | ☐ Yes | ☐ No |
| Do you have any problems emptying your bladder completely? | ☐ Yes | ☐ No |
| Any difficulty with erection or ejaculation? | ☐ Yes | ☐ No |
| Any testicle pain or swelling? | ☐ Yes | ☐ No |
| Date of last prostate and rectal exam? | ☐ Yes | ☐ No |

*PLEASE COMPLETE THE NEXT PAGE IF YOU ARE 65 YEARS OLD AND OVER*

## GERIATRICS ONLY (65 YEARS AND OVER)

| ACTIVITIES OF DAILY LIVING (ADL) | | |
|---|---|---|
| Independent | ☐ Yes | ☐ No |
| Difficulty feeding oneself | ☐ Yes | ☐ No |
| Difficulty dressing oneself | ☐ Yes | ☐ No |
| Difficulty going to the bathroom | ☐ Yes | ☐ No |
| Difficulty walking unassisted | ☐ Yes | ☐ No |
| Difficulty washing oneself | ☐ Yes | ☐ No |
| Difficulty grooming | ☐ Yes | ☐ No |
| Other, please specify: ___ | | |

| INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) | | |
|---|---|---|
| Fully able to manage the household | ☐ Yes | ☐ No |
| Unable to do one's own shopping | ☐ Yes | ☐ No |
| Unable to do one's own cooking | ☐ Yes | ☐ No |
| Unable to do one's own house cleaning | ☐ Yes | ☐ No |
| Unable to do one's own laundry | ☐ Yes | ☐ No |
| Unable to use the telephone by oneself | ☐ Yes | ☐ No |
| Unable to manage one's own medications | ☐ Yes | ☐ No |
| Unable to manage one's own money | ☐ Yes | ☐ No |
| Unable to drive | ☐ Yes | ☐ No |
| Other, please specify: ___ | | |

| RISK FOR FALLS | | |
|---|---|---|
| Falls are a serious health concern related to many diseases, medical conditions or medications you may be taking. Falls can result in serious injury that we want to take proactive precautions to prevent whenever possible.<br>To assist in identifying your level of risk for fall, check any of the following that apply. | | |
| Are you 65 or older? | ☐ Yes | ☐ No |
| Have you fallen within the last 3 months? | ☐ Yes | ☐ No |
| Are you unsteady on your feet or have general weakness? | ☐ Yes | ☐ No |
| Are you taking any medications that cause fatigue or dizziness? | ☐ Yes | ☐ No |
| Have you had a stroke in the past? | ☐ Yes | ☐ No |
| Do you have any progressive neurological disease? | ☐ Yes | ☐ No |
| Do you have diabetes? | ☐ Yes | ☐ No |
| Do you have neuropathy, arthritis or joint disease of the lower extremities? | ☐ Yes | ☐ No |
| Do you have visual disturbances? | ☐ Yes | ☐ No |
| Do you have fatigue, dizziness or declined agility? | ☐ Yes | ☐ No |
| Do you have a fear of falling? | ☐ Yes | ☐ No |
| Do you have painful feet? | ☐ Yes | ☐ No |
| Do you have to rush to get to the bathroom in time? | ☐ Yes | ☐ No |
| Other, please specify: ___ | | |
| **NOTE:** If three or more of the statements above apply to you, you may be at risk for falls. Please discuss with your physician for recommendations. | | |

***PHYSICIAN USE ONLY (COMMENTS/NOTES)***

**PHYSICIAN RECOMMENDATION:** ☐ Low risk for falls ☐ High risk for falls