Medicare Wellness Visit
Patient Questionnaire

Provider Initials	Date

Name: _____

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____

Gender (circle)**:** Male Female **Race** (circle): Caucasian African American Latino Other:_____

Drug Allergies: _____

List medications and dose you are on:

Medication:	Dose:	Medication:	Dose:	Medication:	Dose:

Have you ever used Tobacco? (circle) No Yes

If yes, Type (circle) Cigarettes Chewing Pipe Cigar _____packs per day for the last_____years

Alcohol use? _____drinks per (circle) day week month

Recreational drug use? (circle) No Yes Type(s): _____

What is your (current/former) occupation? _____

Who lives with you at home? _____

Do you exercise? No Yes If yes,_____times per week Type: _____

Nutrition: How many servings of fruit/vegetables do you consume per day? _____

Whole Grains? _____Protein?_____Fat?_____

Do you always fasten your seat belt? No Yes Do you wear sunscreen? No Yes

Do you have any problems performing dressing, feeding, toileting, or grooming? No Yes

Do you need help with shopping, food preparation, housekeeping, taking medicine or managing finances? No Yes

Have you ever had any of the following health problems? Circle all that apply. NONE

Heart Attack	Tuberculosis (TB)	Back Problems	Kidney Infections
Heart Disease	Pneumonia	Diabetes	AIDS/HIV
Heart Murmur	Stroke	Hypoglycemia	Thyroid Problems
Chest Pain	Seizures	Hepatitis	Sinus Disease
High Blood Pressure	Head Injury	Jaundice	Hearing Loss
Asthma	Migraines	Bleeding Disorder	Reflux Disease
Emphysema	Meningitis	Anemia	Ulcers
Arthritis	Cystic Fibrosis	Cancer Type:_____	

Other_____

Please list any surgeries you have had including dates:

_____

_____

_____

_____

Name: _____Date of Birth: _____/_____/_____

Have any of your family members had the following health problems? Circle all that apply ☐ NONE

☐ Heart Disease	☐ Stroke	☐ Hepatitis	☐ Thyroid Problems
☐ High Blood Pressure	☐ Migraines	☐ Bleeding Disorder	☐ Hearing Loss
☐ Tuberculosis (TB)	☐ Arthritis/ Joint Pain	☐ Reflux Disease	☐ AIDS/HIV
☐ Asthma	☐ Diabetes	☐ Ulcers	☐ Cancer Type _____

☐ Other: _____

Have you had any of the following in the last 2 weeks: Circle all that apply

General: No Problems ☐
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats

Skin: No Problems ☐
- ☐ Skin lesions
- ☐ Pigmentation changes

Eyes: No Problems ☐
- ☐ Blurry vision
- ☐ Double vision
- ☐ Change in vision

Genitourinary: No Problems ☐
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Blood in urine

Musculoskeletal: No Problems ☐
- ☐ Joint/back pain
- ☐ Muscle weakness

Ears: No Problems ☐
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Ear Pain
- ☐ Dizziness

Nose: No Problems ☐
- ☐ Congestion/obstruction
- ☐ Post nasal drip

Throat: No Problems ☐
- ☐ Recent voice changes
- ☐ Difficultly swallowing

Gastrointestinal: No Problems ☐
- ☐ Nausea/vomiting
- ☐ Heartburn
- ☐ Abdominal pain
- ☐ Constipation/diarrhea
- ☐ Blood in stool

Cardiovascular: No Problems ☐
- ☐ Chest pain
- ☐ Swollen ankles
- ☐ Palpitations

Pulmonary: No Problems ☐
- ☐ Wheezing
- ☐ Coughing
- ☐ Difficulty breathing

Neuro/Psych: No Problems ☐
- ☐ Numbness/weakness
- ☐ Tingling
- ☐ Depression/anxiety

Hem/Endoc: No Problems ☐
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Heat/cold intolerance
- ☐ High blood sugar

Other Physicians (Specialists)	Specialty	Reason

Do you have an Advanced Directive (circle): Yes ☐ No ☐

Advanced Care Planning Consent: I consent to discuss end-of-life planning issues with my healthcare provider (circle): Yes ☐ No ☐

_____ _____

Patient/Guardian Signature Date