

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

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