Medicare Annual Wellness Visit – Patient History

Name _____ Date _____ Birthdate _____

Languages Spoken _____ Date of Last Wellness Visit _____

Do you have an advance directive or living will? ❑ Yes ❑ No ❑ Don't Know ❑ Want Information

Past Medical History (*please circle all that apply)*

Childhood Diseases:	asthma	chicken pox	measles	meningitis
	mumps	rheumatic fever	other _____	
Adult Illnesses:	asthma	arthritis	bipolar disorder	bowel disease
	cancer	COPD	depression/anxiety	diabetes
	eczema	emphysema	GERD	glaucoma
	heart problems	hepatitis	high blood pressure	high cholesterol
	HIV	migraine	schizophrenia	seizure
	stroke	TB	thyroid disease	ulcer

Other _____

Operations

Type	When	Where
_____	_____	_____
_____	_____	_____

Hospitalizations (*other than the above operations)*

Type	When	Where
_____	_____	_____
_____	_____	_____

Other Healthcare Providers

Problem	Name of Provider	Date of Last Visit
_____	_____	_____
_____	_____	_____

Current Medications/Over-the-Counter/Vitamins/Herbs

(*if you don't know the name, please indicate why you take them)*

_____

_____

_____

_____

Allergies

Medications _____

Other (food, latex, environmental)_____

Family History

Father: ❑ Living – age ____, health problems _____
❑ Deceased – age _____ and cause of death _____

Mother: ❑ Living – age _____, health problems _____
❑ Deceased – age _____ and cause of death _____

Siblings: ❑ Living – age(s) _____, health problems _____
❑ Deceased – age(s) _____ and cause of death _____

General Family History

(*check and write which family member in relationship to you – mother, father, siblings…)*

❑ Diabetes _____ ❑ Heart Disease _____
❑ Stroke _____ ❑ Cancer _____
❑ High Blood Pressure _____ ❑ Mental Illness _____
❑ High Cholesterol _____

Health Maintenance Screening

Last tetanus shot _____ Last flu shot _____ Last pneumonia shot _____
Last mammogram _____ Colonoscopy/sigmoidoscopy _____
Stool test for blood _____ Last cholesterol test_____ Last Pap _____
Last EKG _____ Any abnormal tests _____ Last prostate exam/test _____
Do you need help with: ❑ dressing ❑ hygiene ❑ eating ❑ chores ❑ walking ❑ other _____

Current Problems (*please circle all that apply)*

General:..... fatigue ..... fever ..... night sweats ..... weight gain/loss
Skin: ..... hives ..... rashes ..... other _____
Head:..... fainting ..... severe headaches
Eye/Ear:..... pain ..... difficulty seeing/hearing
Dental, lip or throat:... dentures..... difficulty swallowing ..poor teeth ..... tooth pain
Heart:..... racing ..... heart murmur ..... severe chest pains
Lung: ..... chronic cough ..... difficulty breathing .... cough up phlegm/blood ... abnormal chest x-ray
Breast: ..... lumps ..... pain ..... nipple discharge
Gastro-intestinal: ..... nausea ..... constipation ..... stomach pains/bloating .... vomited blood
rectal bleeding ..... loose/black stools ..... heartburn
Genital/Urinary: ..... bloody urine ..... penis discharge ..... problem with erection
frequent/burning with urination ..... difficulty starting/leaking urine
vaginal itching/odor
Blood: ..... clotting ..... abnormal bleeding .... bruising easily
Muscle, Bone, Joint:.. pain ..... swelling
Mental Health: ..... nervousness ..... problem sleeping ..... hearing voices ..... seeing things
sadness ..... thoughts of hurting myself or someone else
drug or alcohol abuse

Other _____

Sexual

Are you in a sexual relationship? ❑ Yes ❑ No Partner: ❑ Male ❑ female

How long with current partner(s)? _____ How many sex partners have you had in your life? _____

Bleeding/Pain after sexual relations? ❑ Yes ❑ No Are you satisfied with your sex life? ❑ Yes ❑ No

Female Only

First day of last period _____ Any abnormal Pap smear results? ❑ Yes ❑ No

Method of birth control _____ How long on birth control? _____

Number of: Pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Do you do a self-breast exam monthly? ❑ Yes ❑ No

How old were you when you went through menopause? _____

Male Only

Do you do a self-testicular exam monthly? ❑ Yes ❑ No

Social History

❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single

Occupation _____

Who do you live with? _____

Do you feel safe in your home? ❑ Yes ❑ No Are you afraid of anyone? _____

Is there a gun in your home? ❑ Yes ❑ No If so, is the gun locked when not in use? ❑ Yes ❑ No

Has anyone ever threatened/hit/pushed/abused you? _____

Have you ever been forced to have sex/do something sexual you didn't want to do? ❑ Yes ❑ No

Smoke - ❑ Yes ❑ No How much? _____ How long? _____

Drink - ❑ Yes ❑ No How much? _____ How long? _____

Marijuana/cocaine/other Yes ❑ No ❑ How much? _____ How long? _____

Please complete this checklist before seeing your doctor or nurse. Your response will help you receive the best health and health care possible.

1. In the **past four weeks**, how would you rate your health in general?

   ❑ Excellent
   ❑ Very good
   ❑ Good
   ❑ Fair
   ❑ Poor

2. How have things been going for you during the **past four weeks**?

   ❑ Very well; could hardly be better
   ❑ Pretty well
   ❑ Good and bad parts about equal
   ❑ Pretty bad
   ❑ Very bad; could hardly be worse

3. In the **past two weeks**, how often have you been bothered by

   a. Little interest or pleasure in doing things
      ❑ Not at all
      ❑ Several days
      ❑ More than half the days
      ❑ Nearly every day

   b. Feeling down, depressed, or hopeless
      ❑ Not at all
      ❑ Several days
      ❑ More than half the days
      ❑ Nearly every day

4. In the **past four weeks**, how much physical pain have you generally had

   ❑ No pain
   ❑ Very mild pain
   ❑ Mild pain
   ❑ Moderate pain
   ❑ Severe pain

5. Have you fallen two or more times in the **past year**?

   ❑ Yes ❑ No

6. Are you afraid of falling?

   ❑ Yes ❑ No

7. Do you smoke or chew tobacco?

   ❑ No
   ❑ Yes, and I might quit
   ❑ Yes, but I'm not ready to quit

8. If you smoke or chew:

   ❑ How much do you smoke or chew?

   _____

   ❑ How long have you smoked/chewed?

   _____

9. In the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

   ❑ 10 or more drinks per week
   ❑ 6-9 drinks per week
   ❑ 2-5 drinks per week
   ❑ 1 drink or less per week
   ❑ No alcohol at all

10. In the **past four weeks**, have you used

	Yes	No
Marijuana		
Cocaine		
Methamphetamine		
Heroin		
Other _____		

11. Do you fasten your seat belt when you are in a car?

    ❑ Yes, usually
    ❑ Yes, sometimes
    ❑ No

12. Do you exercise for about 20 minutes three or more days a week?

    ❑ Yes, most of the time
    ❑ Yes, some of the time
    ❑ No, I usually do not exercise this much

13. How many meals a day do you eat? _____

14. Are you following any special diet (low salt, low cholesterol, high fiber, etc.)?

    _____

15. How confident are you that you can control and manage most of your health problems?

    ❑ Very confident
    ❑ Somewhat confident
    ❑ Not very confident
    ❑ I do not have any health problems

How often during the **past four weeks** have you been bothered by any of the following?

	Never	Seldom	Sometimes	Often	Always
Falling or dizziness					
Trouble eating well					
Preparing meals					
Teeth or denture problems					
Problems hearing a phone					
Difficulty driving a car					
Taking medicine the way you were told					
Getting to places that are too far to walk					
Shopping for groceries or clothes without help					
Doing housework without help					
Needing someone's help with your personal care (eating, bathing, dressing, etc.)					

Your Healthy Behavior

Small everyday changes can have a big impact on your health. Think about the changes you would be most interested in making over the next year. Look at the list below and **choose one or more**.

- ❑ Exercise regularly, eat better, and/or lose weight
- ❑ Cut back or quit smoking or using tobacco
- ❑ Get a flu shot
- ❑ Return to the doctor to get tested for high blood pressure, high cholesterol and diabetes OR if I already have any of them, return to the doctor for checkups for these conditions
- ❑ Cut back or quit drinking alcohol
- ❑ Seek treatment for drug or substance abuse
- ❑ I will commit to keep up all of the healthy things I do now
- ❑ Other: _____

Changes like drinking water rather than soda or walking every day can help you stay healthy or help you better control illnesses you may already have. You can learn new ways to handle stress or quit smoking. Remember, even small changes can be difficult and take a long time. It may be helpful to get support from your family, friends, community or your provider.

Now that you have selected your healthy behavior(s) above, answer questions 1 – 3. For each question, use the scale provided and pick a number from 0 through 5.

1. Thinking about your healthy behavior(s), do you want to make some small lifestyle changes in this area to improve your health?

❑ 0 — I don't want to make changes now
❑ 1
❑ 2 — I want to learn more about changes I can make
❑ 3
❑ 4 — Yes, I know the changes I want to start making
❑ 5

2. How much support do you think you would get from family or friends if they knew you were trying to make some changes?

❑ 0 — I don't think family or friends would help me
❑ 1
❑ 2 — I think I have some support
❑ 3
❑ 4 — Yes, I think family or friends would help me
❑ 5

3. How much support would you like from Grace Health to make these changes?

❑ 0 — I do not want to be contacted
❑ 1
❑ 2 — I want to learn more about programs that can help me
❑ 3
❑ 4 — Yes, I would like a lot of support from FHC
❑ 5