Medicare Annual Wellness Visit

Please help us serve you better at the time of your Medicare Initial Annual Wellness Visit by supplying as much information as possible on the following pages:

Printed Name: ______________________________

Birthdate: _________________________________ Date: _________________________

I. Past Medical History:

A. Allergy: ____

Drug Sensitivity /Intolerance:__________________________________

B. All prior medical history including diseases, hospitalizations, injuries, and surgery (and childbirth if female):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

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C. Current prescription and non-prescription medications & dosage including vitamins, supplements, and aspirin:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

D. Current Physicians and other Healthcare Professionals involved in your medical care:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

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II. Family History of Medical Problems:

A. Grandparents: Age at death & cause of death IF deceased:

B. Parents: Age at death & cause of death IF deceased:

C. Siblings:

D. Children:

E. Spouse:

F. Other:

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Ill. Social History:

A. Tobacco Use:
____

B. Alcohol Use:
____

C. Current Recreational Drug Use:
____

D. Caffeine Intake:
____

E. Exercise:
____

F. Occupation or Former Occupation:
____

IV. Activities of Daily Living (Please Check Off Your Level of Function below as Independent, Assistance Required or Unable):

	Independent	Assistance	Unable
Telephone:	______	______	______
Shopping:	______	______	______
Driving:	______	______	______
Meal Preparation:	______	______	______
Housekeeping:	______	______	______
Taking medications:	______	______	______
Managing finances:	______	______	______

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V. Safety and Fall Risk Assessment:

	YES	NO
A. Hearing Impairment?	______	______
B. Vision Impairment?	______	______
C. Have you fallen in the last 6 months?	______	______
D. Loose or throw rugs in your home?	______	______
E. Seat belt usage?	______	______
F. Safety devices in tub or shower?	______	______
G. Use Cane, Walker, or wheelchair?	______	______
H. Dizziness?	______	______
I. Urinary or bowel lack of control?	______	______

VI. Depression Assessment:

A. Over the past two weeks, have you felt down, depressed, or hopeless?	______	______
B. Over the past 2 weeks, have you felt little interest or pleasure in doing things?	______	______

VII. Advance Directives:

We strongly encourage you to complete the following two forms if you haven't already done so:

A. Designation of a Personal Representative (Health Insurance Portability and Accountability Act or HIPAA). Please complete the attachment.

B. Health Care Proxy and instructions for completion. Please complete the attachment.