Please list pharmacy you would like us to use for your medications.

Pharmacy	**Phone Number**	**Fax Number**

Since your last visit:

1. Have you been diagnosed with any new medical conditions? ___Yes ___No

If Yes (give details)

2. Have you undergone any recent surgical procedures? ___Yes ___No

If Yes (give details)

3. Have you had any medication, vitamin or supplement changes? ___Yes ___No

4. Has there been any change in your family history? ___Yes ___No

If Yes (give details)

5. Do you currently smoke or use tobacco products? ___Yes ___No

6. Do you drink alcohol? ___Yes ___No

If yes, how many drinks _____ in a [day, week or month]

Medication List: (please list all medications you are taking ***OR ATTACH LIST***)

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

[Note : include inhalers, nasal sprays, etc]

Allergy List: (please list all allergies you have to medications ***OR ATTACH LIST***)

Medication Allergy	Reaction

Provider List: (please list any other doctors/specialists you are seeing ***OR ATTACH LIST***)

Doctor	Specialty

Current activity level (check which describes most accurately):

__Not much (sedentary) __Minimal __Active, but No Exercise __Some Exercise

__Regular Exercise :_____

Please describe your current diet (check all that apply):

__ Well-balanced, controlled portions ___ Unbalanced ___ Excessive Portions

__ Low Salt __ Low Fat ___ Low Carbs _____ Restricted calories (_____ cal/day)

___ Other: _____

End of Life Planning

Do you have a written advance directive, living will, power of attorney, or end of life planning (such as resuscitation desire)? ___Yes ___No

If yes, is this in your chart? ___Yes ___No ___Unsure

Do you wish to discuss any end of life issues during this exam? ___Yes ___No

Immunizations:

Please list the last time you were vaccinated for the following:

Name	Last Date of Vaccination
Pneumonia Shot (Pneumovax)	
Flu Shot (Influeza Vaccine)	
Shingles Vaccine (Zostavax)	
Tetanus Shot (DT, Td, Tdap)	

Preventative Testing:

Name	Date Last Done
Colonoscopy	
Electrocardiogram (EKG)	
Cardiac Stress Testing	
Prostate Testing (males only)	
Mammogram (females only)	
Pelvic Exam/PAP smear	
DEXA/Bone Scan	

	YES	NO
In the last 2 weeks have you felt depressed?		
Have you dropped any of your hobbies/interests?		
Do you prefer to stay at home rather than going out?		
Are you having significant trouble with your memory?		
Do you feel sad most of the time?		
	YES	NO
Do you feel you have any significant memory problems?		
Have you forgotten what you had for dinner yesterday?		
Do you have to keep lists so you don't forget things?		
Do you frequently lose things at home or at work?		
Have you ever gotten lost while driving?		
Have you ever forgotten why you are at a store or other place?		
Have you had trouble balancing your checkbook lately?		
Do people often accuse you of repeating yourself?		
	YES	NO
Do you feel you have any significant safety concerns?		
Do you have any trouble seeing?		
Do you have any trouble speaking?		
Do you have any trouble hearing?		
Do you have any trouble bathing?		
Do you have any trouble dressing?		
Do you have any trouble eating?		
Do you feel unstable or unsteady when standing?		
Do you have any trouble using stairs, if you have them?		
Have you fallen or almost fallen in the last 60 days?		
Do you know of any fire hazards in your home?		
Would you have any trouble getting 911 help if needed?		

Medicare Annual Wellness Assessment Form

Check all that apply:

General- ☐ Weight loss or gain ☐ Fatigue ☐ Fever or chills ☐ Weakness ☐ Trouble sleeping
Skin- ☐ Rashes ☐ Lumps ☐ Itching ☐ Dryness☐ Color changes ☐ Hair and nail changes
Head- ☐ Headache ☐ Head injury
Ears- ☐ Decreased hearing ☐ Ringing in ears (tinnitus) ☐ Earache☐ Drainage
Eyes- ☐ Vision Changes ☐ Glasses or contacts ☐ Pain ☐ Redness ☐ Blurry or double vision ☐ Flashing lights ☐ Glaucoma ☐ Cataracts
Nose- ☐ Stuffiness ☐ Discharge ☐ Itching ☐ Nosebleeds☐ Sinus pain
Throat- ☐ Teeth issues ☐ Gums ☐ Bleeding☐ Dentures ☐ Sore tongue ☐ Dry mouth ☐ Sore throat ☐ Hoarseness ☐ Thrush ☐ Non-healing sores
Neck- ☐ Lumps ☐ Swollen glands ☐ Pain☐ Stiffness
Breasts- ☐ Lumps ☐ Pain ☐ Discharge
Respiratory-☐ Cough ☐ Sputum☐ Coughing up blood ☐ Shortness of breath ☐ Wheezing ☐ Painful breathing
Cardiovascular-☐ Chest pain or discomfort ☐ Tightness ☐ Palpitations☐ Shortness of breath with activity ☐ Swelling in legs ☐ Sudden awakening from sleep with shortness of breath
Gastrointestinal- ☐ Swallowing difficulties ☐ Heartburn ☐ Change in appetite ☐ Nausea ☐ Change in bowel habits ☐ Rectal bleeding ☐ Constipation ☐ Diarrhea ☐Yellow eyes or skin
Urinary- ☐ Frequency ☐ Urgency ☐ Burning or pain ☐ Blood in urine(hematuria) ☐ Incontinence ☐ Change in urinary strength
Genital-
Males Only -☐ Pain with sex ☐ Hernia ☐ Penile discharge ☐ Sores ☐ Masses or pain ☐ Erectile dysfunction ☐ STD's
Females Only- ☐ Pain with sex ☐ Vaginal dryness ☐ Hot flashes ☐ Vaginal discharge ☐ Itching or rash ☐ STD's
Vascular- ☐ Calf pain with walking (Claudication) ☐ Leg cramping
Musculoskeletal- ☐ Muscle or joint pain ☐ Stiffness ☐ Back pain ☐ Redness of joints ☐ Swelling of joints ☐ Trauma
Neurologic-☐ Dizziness ☐ Fainting ☐ Seizures ☐ Weakness ☐ Numbness ☐ Tingling☐ Tremor
Hematologic- ☐ Ease of bruising ☐ Ease of bleeding
Endocrine- ☐ Head or cold intolerance ☐ Sweating ☐ Frequent urination ☐ Thirst
Psychiatric- ☐ Nervousness ☐ Depression ☐ Memory loss ☐ Stress

[DO NOT FILL OUT- BRING IN TO NEXT APPOINTMENT]

Patient Name _____ Date of Birth _____

Exam Date _____

Weight _____ Height _____ Body Mass Index _____

Blood Pressure _____ Pulse _____ RR _____ Pulse Ox _____

Vision R _____ L _____

Hearing _____

Provider Notes: