Medicare Wellness Intake Form

Name: _____ **DOB**:_____
Preferred Pharmacy: _____

What are your priorities for today's visit?

_____

_____

Do you have Advanced Directives? YES NO

Do you have any **NEW** allergies? (If new patient, please disregard)

_____

_____

Do you have any **NEW** medications? (If new patient, please disregard)

_____

_____

How often have you been bothered by the symptoms below over the last two weeks?

Little interest or pleasure in doing things in the last 2 weeks? (please circle)

Not At All / Several Days / More than half the days / Nearly every day

Feeling down, depressed, or hopeless in the last 2 weeks? (please circle)

Not At All / Several Days / More than half the days / Nearly every day

Did you receive the flu vaccine in the prior flu season? YES NO
Did you receive the flu vaccine this current flu season? YES NO

Please answer if you are 65 years or older:
Have you ever received a Pneumonia vaccine? YES NO
If yes, was it less than 5 years ago? YES NO

Any **NEW** surgeries or procedures since your last wellness?

_____

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Patient Sticker
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FIN _____

The Healing Sanctuary

Medicare Wellness Intake Form

Recreational:	Yes	No	Comments
Tobacco			
Vaping			
Alcohol			
Substance			
Nutrition:			
Do you eat a regular diet?			
Any Caffeine? How much?			
Any vitamins or supplements?			
Want to lose weight?			
Do you feel highly stressed?			
Home Environment			
Do you live in your own home?			
Who do you live with?			
Any home medical equipment and what?			
Employment/School:			
Are you retired?			
What did you do for a living?			
Highest level of education?			
Exercise:			
Do you exercise?			
If so, how many days and how long?			
Light/moderate/vigorous			
Hours of sleep?			

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Health Risk Assessment Form for Medicare Patients

Do you use a cane or a walker?	Yes	No
Do you need someone to help you get up in the morning?	Yes	No
Do you have trouble consistently taking or remembering to take all your medications as prescribed?	Yes	No
Can you get to places out of walking distance without help?	Yes	No
Can you go shopping for groceries or clothes without help?	Yes	No
Can you prepare your own means?	Yes	No
Can you do your housework without help?	Yes	No
Can you manage your money without help?	Yes	No
Can you keep track of your own medications without help?	Yes	No

Home Safety Screening

	Yes	No
Are emergency numbers kept by the phone/fridge and updated regularly?		
Are firearms stored unloaded and securely locked?		
Do all stairways have rails or banisters?		
Are all household members aware of the dangers of smoking, especially in bed?		
Are working smoke alarms and fire extinguishers available for use?		
Do all household members know how to use smoke alarms and fire extinguishers?		
Have throw rugs been removed or fastened down?		
Are non-slip mats in all bathtubs and showers?		
Are doorways and stairs free of clutter?		
Are sidewalks and all outdoor steps clear of tools, toys or other articles?		
Are all electrical cords in working order, easily seen and not run under rugs/carpets or wrapped around nails?		

When was your last Colonoscopy? _____
Where was it completed? _____

When was your last mammogram? _____
Where was it completed? _____

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Medicare Wellness Intake Form

Please answer these questions based on the last four weeks

How would you rate your general health?	Excellent / Very Good / Good / Fair / Poor
How have things been going for you in general?	Very Well / Pretty Well / Good and Bad / Pretty Bad / Very Bad
Is someone available to help you if you need and wanted help?	Not at all / Yes, quite a bit / Yes, some / Yes, a little / No, not at all
Has your physical and emotional health limited you from social activities with family, friends, neighbors, or groups?	Not at all / Slightly / Moderately / Quite a bit / Extremely
How often have you had trouble eating well?	Never / Seldom / Sometimes / Often / Always
How often have you had teeth or denture problems?	Never / Seldom / Sometimes / Often / Always
How often have you had problems using the telephone?	Never / Seldom / Sometimes / Often / Always
How often have you been bothered by sexual problems?	Never / Seldom / Sometimes / Often / Always
Are you having difficulties driving your vehicle?	I do not drive / No / Sometimes / Yes
Do you always wear your seat belt when you are in a vehicle?	Always / Occasionally / Never
How confident are you that you can control and manage most of your health problems?	I do not have any / Very confident / Somewhat / Not very

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Functional Assessment

	Independent	Requires Assistance	Dependent
Bathing			
Dressing			
Toileting			
Transferring bed to chair continence			
Feeding			

Fall Risk Assessment

Areyou65yearsorolder?	Yes	No
Have you had any falls within the past year?	Yes	No
Have you had a fall with injury?	Yes	No
Do you have a fear of falling?	Yes	No
Do you feel unsteady when standing or walking?	Yes	No

Please check yes or no if you've experienced any of these symptoms in the last month

1. Constitutional:

	YES	NO
Weight Gain		
Weight Loss		
Fever		
Fatigue		
Chills		
Night Sweats		
Hot Flashes		

2. Eyes:

	YES	NO
Eye pain		
Vision disturbance		
Dry eyes		
Watery eyes		
Periorbital Swelling	N/A	N/A
Itchy Eyes		

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3. Ears, Nose, Mouth, Throat:

	YES	NO
Ear pain		
Nosebleeds		
Hearing Loss		
Hoarseness		
Ringing in ears		
Sore throat		
Mouth sore		
Drainage		
Congestion		
Difficulty swallowing		
Dental pain		

4. Musculoskeletal:

	Yes	No
Back pain		
Neck pain		
Joints swelling/stiffness/pain		
Extremity pain		
Decreased Range of Motion		
Muscle Pain		
Unable to bear weight		
Muscle Spasms/Cramps		

5. Respiratory/Lungs

	YES	NO
Shortness of breath		
Asthma		
Sleep Apnea		
Productive cough		
Non-Productive cough		
Wheezing		
Cyanosis (blue in the lips or fingers)		
Snoring		
Daytime Drowsiness		

6. Neurological

	YES	NO
Numbness or tingling		
Headaches		
Loss of balance		
Trouble with speech		
Forgetfulness/Confusion		
Syncope		
Weakness		
Dizziness		
Loss of consciousness		
Tremors		
Seizures		
Double Vision		

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7. Cardiovascular:

	YES	NO
Chest pain/tightness		
Irregular rapid heart beat		
Palpitations		
Varicose Veins		
Swelling in legs/arms		
Shortness of breath while laying down		

9. GI:

	Yes	No
Black/Bloody stools		
Abdominal pain		
Nausea/Vomiting		
Heartburn/acid		
Constipation		
Loss of appetite		
Use of laxatives		
Cramping		
Diarrhea		
Rectal bleeding		

8. Integumentary:

	Yes	No
Rash		
Change in skin color		
Itching		
Lesions/Sores		
Breast Pain/Lumps/Discharge		
Changes in moles		
Sun sensitivity		
Dry skin/nails/lips		
Non-healing sores		
Problems with scarring		
Subcutaneous nodules	N/A	N/A
HX of blistering sunburn	N/A	N/A

10. Psych/Social:

	Yes	No
Hallucinations		
Behavioral changes		
Depression		
Suicidal ideations		
Self-Harm		
Anxiety		

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11. GU:

	Yes	No
Frequent Urination		
Urinary Urgency		
Frequent urination at night		
Painful urination		
Blood in urine		
Testicular pain		
Pelvic pain		
Abnormal urine smell/color		
Abnormal menstruation		
Burning		
Menopause		
Pain during intercourse		
Weak urinary stream		
Urinary Retention		
Proteinuria	N/A	N/A
Incontinence		

12. Hematologic/Lymph

	Yes	No
Bleeding easily		
Swollen glands		
Delayed healing		
Bruising		
Swollen lymph nodes		
Anemia		

14. Endocrine:

	Yes	No
Decreased appetite		
Increased appetite		
Heat/Cold intolerance		
Increased thirst		
Increased sweating		

13. Allergy/Immunologic:

	Yes	No
Food allergy		
Environmental Allergy		
Medication allergy		
Hay fever		
Hives		
Immune disorders		

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