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)*

_____

_____

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

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

Any new surgeries or procedures since your last wellness? _____

_____

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Social History

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?			

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? _____

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 needed and wanted help?	Yes, as much as I want	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	

Functional Assessment

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

Fall Risk Assessment

Are you 65 years or older?	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

Constitutional:

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

Eyes:

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

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		

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		

Musculoskeletal:

	Yes	No
Back pain		
Neck pain		
Joints swelling/stiffness/pain		
Extremity pain		
Decreased ROM		
Myalgia		
Unable to bear weight		
Muscle Spasms/Cramps		

Endocrine:

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

Allergy/Immunologic:

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


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