Medicare Wellness Visit

*Please take a moment to complete this form in order for us to best serve you. Thank you so much for trusting us with your health care. – The Dr.Phillips Medical Wellness Team*

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco use: \_\_\_Yes \_\_\_\_No

If yes, how much per day? \_\_\_\_\_\_\_\_\_\_\_\_

Alcohol use: \_\_\_\_\_\_\_\_\_\_\_\_

Drug use: \_\_\_\_\_\_\_\_\_\_\_\_

**Please list any other providers regularly involved with your care:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_ Well- balanced, portion controlled \_\_\_ Unbalanced \_\_\_ Excessive portions

\_\_\_ Low salt \_\_\_ Low fat \_\_\_ Low carbs \_\_\_ Restricted calories (\_\_\_\_\_\_cal/day)

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please described your current level of activity:**

\_\_\_ Minimal \_\_\_ Active, but no exercise \_\_\_Some exercise \_\_\_ Regular exercise

**General screening:**

Do you have any significant safety concerns? \_\_\_ Yes \_\_\_ No

Do you have any trouble seeing, hearing or speaking? \_\_\_ Yes \_\_\_ No

Do you have any trouble bathing, dressing or eating? \_\_\_ Yes \_\_\_ No

Have you fallen or almost fallen in the last 60 days? \_\_\_ Yes \_\_\_ No

Any hospitalizations in the past year? \_\_\_ Yes \_\_\_ No

Do you have any fire hazards in your home? \_\_\_ Yes \_\_\_ No

Do you have any urinary concerns or incontinence? \_\_\_ Yes \_\_\_ No

**Cognitive screening:**

Do you feel you have any significant memory problems? \_\_\_ Yes \_\_\_ No

Have you ever gotten lost while driving? \_\_\_ Yes \_\_\_ No

**End-of-Life Planning:**

Dr.Phillips Medical Wellness Center honors our patients’ end of life wishes, including: advanced directives, living wills and resuscitations desires…

Do you wish to discuss any end of life issues during this exam? \_\_\_Yes \_\_\_No

**When was your last:**

Colonoscopy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fecal occult blood test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Podiatry visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bone density \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flu vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tdap or TD vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shingles vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Women:*

Mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pelvic exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_