MEDICARE ANNUAL WELLNESS VISIT

FAMILY MEDICINE CENTERS OF SOUTH CAROLINA, LLC

____Springwood Lake ____Midtown ____Woodhill ____Saluda Pointe ____Lake Murray

Name: _____ Ethnic Background: _____

Race: _____ Age: _____ Sex: _____ Marital Status: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR OWN MEDICAL HISTORY:

(1) Chronic Medical Problems (i.e.: Diabetes, Hypertension, Arthritis, Heart Disease, Thyroid, Asthma, Depression, etc.):

_____

_____

(2) Current Medicines & Supplements (i.e.: Heart drugs, Inhaler, Insulin, Antacid, Hormone, Blood Thinner, Vitamins):

_____

_____

(3) Serious Illnesses (i.e.: Hepatitis, HIV, Ulcer, TB, Kidney Stones, Meningitis, Pneumonia, Heart Attack, Stroke, etc.):

_____

(4) Major Injuries (i.e.: Fracture, Burn, Concussion, Gunshot, Torn Cartilage, Ruptured Spleen, Ruptured Disc, etc.):

_____

(5) Surgery (i.e.: Biopsy, Tonsils, Appendix, Gall Bladder, Hernia, Coronary Bypass, Hip, Knee, Colonoscopy, etc.):

_____

(6) Hospital Admissions (i.e.: Serious Illness, Bad Injury, Surgery, Pregnancy, Nervous Breakdown, Diagnostic Work, etc.):

_____

_____

(7) Physical Impairments (i.e.: Deafness, Eye Glasses, Dentures, Cane, Colostomy, Birth Defect, Amputation, etc.):

_____

(8) Allergies/Drug Reactions (i.e.: Insect Bites, Hives, Asthma, Hay Fever, Sinus, Eczema, Drug Reaction, etc.):

_____

(9) Habits (i.e.: Smoking, Alcohol, Caffeine, Laxatives, Nasal spray, Pain Medicine, Illegal Drugs, etc.):

_____

(10) Social Background (i.e.: Education, Employment, Marital Status, Children, Military, Hobbies, etc.):

_____

(11) Do you have any medical problems <u>now</u> that require prompt medical attention?

_____

(12) Please list the doctors, other medical providers and suppliers you have used within the past 3 years (i.e.: Podiatrist, Specialists, Gynecologist, Psychiatrist, Optometrist, Chiropractor, Physical Therapist, equipment supplier, etc.):

_____

_____

FAMILY MEDICAL HISTORY

LIST ANY DISEASES THAT OCCUR IN MULTIPLE BLOOD RELATIVES:

_____ _____ _____

_____ _____ _____

_____ _____ _____

	END-OF-LIFE PLANNING	YES	NO
(1)	Do you have a written Will which conveys ownership of your property after your death?		
(2)	Have you appointed an Executor to manage your estate after your death?		
(3)	Do you have a Living Will or some other written end-of-life medical directives?		
(4)	Have you appointed a Health Care Agent who can make medical decisions for you just in case you're not able to do so in the future?		
(5)	Have you read the "5 Wishes for End-of-Life Planning"?		

	HEALTH & SAFETY RISKS	YES	NO
(1)	Do you have any safety concerns in your home, workplace, or community?		
(2)	Do you engage in exotic travel or risky activities (i.e.: motorcycle, surfing, skiing, etc.)?		
(3)	Do you fail to wear your seat belt regularly while in a vehicle?		
(4)	Do you have a problem with poor balance/coordination or frequent falls?		
(5)	Has your vision gotten worse lately?		
(6)	Has your hearing gotten worse lately?		
(7)	Do you have chronic or severe pain not well-controlled by your current treatment?		
(8)	Do you have any foot, neck, back or joint problems that impair your function?		
(9)	Do you have sleep problems, bad snoring, or bothersome daytime drowsiness?		
(10)	Have you had problems with bowel or bladder control?		
(11)	Do you have a problem with your sexual function which is bothersome to you?		
(12)	Do you currently smoke or use tobacco?		
(13)	Do you consume more than 2 drinks of liquor, wine or beer per day on the average?		
(14)	Has your weight increased or decreased more than 20 pounds over the past 2 years?		
(15)	Do you get less than 2 hours of exercise per week?		

	MENTAL HEALTH STATUS	YES	NO
(1)	Have you or others noticed that your memory or thinking ability are worse lately?		
(2)	Have you or others noticed that you seem to be tense, nervous or anxious lately?		
(3)	Do you tend to worry a lot lately?		

PATIENT HEALTH QUESTIONNAIRE – 9

	Over the last 2 weeks, how often have you been bothered by any of the following problems? (*Circle your answers*)	**NOT AT ALL**	**SEVERAL DAYS**	**MANY DAYS**	**EVERY DAY**
(1)	Little interest or pleasure in doing things	0	1	2	3
(2)	Feeling down, depressed or hopeless	0	1	2	3
(3)	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
(4)	Feeling tired or having very little energy	0	1	2	3
(5)	Poor appetite, or overeating	0	1	2	3
(6)	Feeling bad about yourself, or feeling that you are a failure	0	1	2	3
(7)	Trouble concentrating on things (such as the newspaper or TV)	0	1	2	3
(8)	Moving or speaking so slowly that other people might have noticed, or being very fidgety and restless	0	1	2	3
(9)	Thought that you would be better off dead or might hurt yourself	0	2	4	6

_____ + _____ + _____

Total Score: _____

If you have any of these problems, how difficult have these problems made it for you to do your work, take care of tasks at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

ACTIVITIES OF DAILY LIVING

CHECK YOUR CURRENT LEVEL OF FUNCTION FOR EACH OF THE DAILY LIVING ACTIVITIES LISTED BELOW:

Activities	Don't Need Help	Sometimes Need Help	Must Have Help
Bathing			
Dressing			
Grooming			
Dental Care			
Using the Toilet			
Transferring			
Walking			
Climbing Stairs			
Eating			
Cooking			
Shopping			
Reading			
Managing your Medicines			
Using the Phone			
House Work			
Doing Laundry			
Driving			
Managing your Finances			

	PREVENTIVE MEDICINE MEASURES	YES	NO
(1)	Have your Blood Sugar and Cholesterol been checked within the past 2 years?		
(2)	Has your stool been checked for blood within the past year?		
(3)	Have you had a screening Colonoscopy for Colon Cancer within the past 5 years? Where _____		
(4)	Have you had a Complete Physical Examination within the past 2 years?		
(5)	Have you had an eye exam within the past 2 years? Where _____		
(6)	Have you seen a dentist within the past 2 years?		
(7)	Have you had Pneumococcal (Pneumonia) Vaccine within the past 10 years?		
(8)	Have you had Influenza (Flu) Vaccine within the past year?		
(9)	Have you had a Tetanus booster within the past 10 years?		
(10)	Have you ever had Shingles Vaccine?		
(11)	If male, have you had a PSA test for Prostate Cancer within the past 2 years?		
(12)	If female, have you taken Osteoporosis medicine with the past year?		
(13)	If female, have you had a DEXA Bone Density Scan within the past 2 years? Where _____		
(14)	If female, have you had Mammograms within the past 2 years? Where _____		
(15)	If female, have you had a Pap Smear within the past 2 years? Where _____		

VITAL SIGNS & VISUAL ACUITY

Weight	_____	FAR VISION	
Height	_____	Corrected	_____
BMI	_____	Uncorrected	_____
Pulse	_____	Right Eye	_____/_____
BP	_____	Left Eye	_____/_____
Resp	_____	Both Eyes	_____/_____
Temp	_____	iFOB	_____

PROVIDER CHECK-LIST

(1) Review Personal Medical & Social History _____

(2) Review Family Medical History _____

(3) Review End-Of-Life Planning _____

(4) Review Health & Safety Risks _____

(5) Review Mental Health Status _____

(6) Review Activities of Daily Living _____

(7) Review Preventive Medicine Measures _____

(8) Provide Patient Education and Counseling (if appropriate). _____

(9) Schedule a complete Physical Exam or regular office visit (if appropriate). _____

(10) Schedule Preventive Medicine services such as DEXA, Mammograms, Pap Smear, Colonoscopy, etc. (if appropriate). _____

(11) Refer to other medical providers within or outside of the Practice (if appropriate). _____

(12) Provide Nutrition Guidelines. _____

(13) Personal Health Care Plan for the next 3 years. _____

(14) Provide Preventive Medicine Check List. _____

____ IPPE ____ IAWV ____ SAWV

Physician Signature: _____ Date: _____