

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**What to expect during your:**

	<b>Welcome to Medicare</b>	<b>Initial Medicare Wellness</b>	<b>Annual Medicare Wellness</b>
	Only available to receive during the 1 <sup>st</sup> 12 months of enrollment	Will receive year following <b>Welcome to Medicare</b> visit	Will receive year following <b>Initial Medicare Wellness</b> visit
Record & Evaluate your medical and family history, current health conditions, and prescriptions.	✓	✓	✓
Check your blood pressure, weight, height, and other vital signs.	✓	✓	✓
Make sure you're up-to-date with preventative screenings and services.	✓	✓	✓
Other further tests, depending on your general health and medical history.	✓	✓	✓
Screening for cognitive impairment	✓	✓	✓
Screening for depression	✓	✓	✓
Screening for falls	✓	✓	✓
Physical examination	✓		
Screening EKG	✓		

Below is a List of items we would like you to answer and then we will review with you.

PLEASE NOTE: We will ask you questions about your health and conditions however this visit is not about addressing those conditions, making medication changes, or addressing any other concerns you have. If you have items you were wanting to discuss please schedule another visit to discuss those. If you are having an acute issue, we may address your acute problem and reschedule this Wellness Visit.

**List of other medical providers you see:**

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**Pharmacies you use:**

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**Tobacco Status (circle those that apply)**

Non-smoker      Current Smoker-      Light      Intermittent      Everyday      Heavy      Interested in quitting

Past smoker      Quit date: \_\_\_\_\_ # of packs \_\_\_\_\_ # of years \_\_\_\_\_

Cigarettes    Cigars      Chew      E-cigarettes

**Functional Status:**

Activities of Daily Living	Independent	With Assistance
Bathes self		
Cleans House		
Continent of bladder		
Continent of bowel		
Cooks		
Dresses self		
Drives		
Feeds self		
Finds way home		
Handles finances		
Handles own medications		
Live independently		
Rides public transportation		
Shops for groceries		
Transfers (in/out of chairs, etc.)		
Uses phone		
Use of bathroom		

Alone      with Spouse/Family    in Facility  
with Friend/Roommate      Other \_\_\_\_\_

**Ambulation:**

Have you fallen in the last year?    Yes    No

How long can you walk or move around at one given time? (circle one)

minutes:    0-5                    5-15                    15-30  
30-60        1hr or more    Unknown

Devices used to assist with ambulation? (circle one)

None          Cane                    Walker  
Wheelchair   Scooter                    Other \_\_\_\_\_

**Home Safety:**

Living Arrangements? (circle one)

Preventative Safety	YES	NO	Comments
Wears seatbelt			
Wears sunscreen			
Operational smoke detectors			
Operational carbon monoxide detectors			
Unlocked guns in home			
Fire exit plan			
Phone in bedroom			
Have throw rugs on floor			
Do you have to step over cords			
Have handrails			
Uses stepstool			
Light near bed			
Tub/Shower floor slippery			
Spousal abuse			
Family violence			
Other			

Sensory Ability	YES	NO	Comments
Hearing difficulty			
Uses hearing aids			
Vision difficult			
Uses eyeglasses			
Uses contacts			

**Advance Care Directive (Living Will)**(circle one):

YES NO

Influenza

Pneumonia

Shingles

Tetanus

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

When: \_\_\_\_\_

Where: \_\_\_\_\_

**Vaccines:** Have you received any vaccines within the last year anywhere outside of our office?

<b>Screenings to be Reviewed:</b>
Alcohol Misuse
Bone Mass Measurement (DEXA)
Colorectal Cancer (fecal occult blood test/cologuard/colonoscopy)
Depression
Diabetes Self-Management Training
Hepatitis B Vaccine
IBT for Obesity
HIV
Medical Nutrition
Prostate Cancer
Mammography
Pelvic Exam
Tobacco Use
Diabetes
Glaucoma
Hepatitis C Virus
Influenza Virus Vaccine
IBT for Cardiovascular Disease
Lung Cancer
Pneumococcal Vaccine
STIs and HIBC
Pap Test
Ultrasound for AAA
Cardiovascular Disease- Lipid panel, cholesterol, Lipoprotein, Triglycerides

**ARE YOU FEELING DEPRESSED?**

Many people think of depression as simply being sad. But it's more than sadness combination of multiple symptoms. Fill out the questionnaire below. This is not complete diagnostic tool, so be sure to talk with your provider about all your depressive symptoms. It's important to discuss potential treatment options that help you.

**The Patient Health Questionnaire (PHQ-9)**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things	0	1	2
2. Feeling down, depressed or hopeless	0	1	2
3. Trouble falling or staying asleep or Sleeping to much	0	1	2
4. Feeling tired or little energy	0	1	2
5. Poor appetite or overeating	0	1	2
6. Feeling bad about yourself—or that you are a failure or have let yourself or family down	0	1	2
7. Trouble concentrating on things, such as reading the newspaper or watching TV?	0	1	2
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2

If you circled any problems on this questionnaire, Mark how

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

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

ADD \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_

TOTAL= \_\_\_\_\_

## Check Your Risk for Falling

Circle "Yes" or "No" for each statement below		Why it matters	
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker are more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking is a sign of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases the chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase the chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or slowed down, are linked to falls.
<b>Total</b>		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubens 2011: 42(6):493-499). Adapted with permission of the authors.

## Review of Systems (ROS) – Adult

Date Completed: \_\_\_\_\_

ELFHP

Please complete ALL pages, as it will become part of your medical record.

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

Please ONLY check if answer YES to CURRENT condition

<b>CONSTITUTIONAL</b>	<b>GASTROENTESTINAL</b>	<b>NEUROLOGICAL</b>	
chills	abdominal pain	dizziness	
fatigue	change in appetite	unstable gait	
fever	change in bowel habits	headaches	
weight gain	constipation	memory loss	
weight loss	diarrhea	numbness	
other	heartburn	seizures	
<b>EYES</b>	nausea	other	
blurred vision	vomiting	<b>HEMATOLOGIC/LYMPHATIC</b>	
change in vision	other	bruising	
glasses/contacts	<b>GENITORURINARY</b>		excessive bleeding
other	painful urination	history of blood clots	
<b>ENT</b>	urinary frequency	history of blood transfusion	
hearing problems	genital lesions	swelling in lymph nodes	
ringing in ears	blood in urine	other	
frequent blood nose	urinary urgency	<b>PSYCHIATRIC</b>	
nasal congestion	urinary incontinence	anxiety	
sneezing	penile discharge	depression	
dentures	vaginal discharge	difficulty concentrating	
difficulty swallowing	change in urine stream	sleep disturbance	
hoarseness	other	suicidal thoughts	
sore throat	<b>MUSCULOSKELETAL</b>		other
other	joint pain		
<b>CARDIOVASCULAR</b>	back pain		
chest pain	joint swelling		
dizziness	muscle pain		
swelling	muscle weakness		
fainting	neck pain		
palpitations	other		
other	<b>INTEGUMENTARY/BREAST</b>		
<b>RESPIRATORY</b>	abnormal moles		
cough	hair/nail changes		
shortness of breath	rash		
coughing up blood	breast tenderness		
frequent wheezing	breast mass		
other	breast discharge		
	other		

