JHL Medical Services
Geriatric Primary Care
Jewish HomeLife

Medicare Well Patient Visits

Gender: M F	____IPPE Welcome to Medicare (G0402) 1 time during first 12 months of coverage	_____Initial AWV (G0438) 1 in a lifetime after coverage for 1 year	____Subsequent AWV (G0439) each year after initial visit

FULL NAME_____ Birthdate_____ Today's Date_____ Office Use (MRN)_____

List any allergies_____

List any medications you take, including over the counter

NAME	DOSE	HOW OFTEN TAKEN		NAME	DOSE	HOW OFTEN TAKEN

List all doctors/ pharmacies/ medical supply companies you have used within the past year:

NAME	**SPECIALTY**	**PHONE NUMBER**

Have you ever been diagnosed with any of the following?

	YES	NO			YES	NO			YES	NO
Diabetes				Asthma				Arthritis		
Hypertension				Emphysema/ COPD				Osteoporosis		
Heart Disease				Heart Burn/ GERD				Gout		
Heart Murmur				Hepatitis				Kidney Disease		
Peripheral Artery Disease				Diverticulosis				Glaucoma		
Rheumatic Fever				Anemia				Restless Leg Syndrome		
Stroke				Bleeding Disorders				Peripheral Neuropathy		
High Cholesterol				Cancer				Mental Health Problems		
Sleep Apnea				Thyroid problems				Other Health Problems		

List any surgeries you have had

Type	Date	Doctor's Name		Type	Date	Doctor's Name

List any major injuries you have had

Type	Date	Doctor's Name		Type	Date	Doctor's Name

List any hospitalizations you have had that are not listed above

Type	Date	Doctor's Name		Type	Date	Doctor's Name

Has anyone in your family been diagnosed with

	Yes	No	Parent	Grandparent	Sibling	Children
Heart Disease						
Hypertension						
Stroke						
Cancer						
Diabetes						
Thyroid						
Osteoporosis						
Glaucoma						
Mental Illness						

Health Habits

Tobacco	Yes	No	Past	Daily Amount	Years of Use	When Stopped		Alcohol	Yes	No	Past	Daily Amount	Years of Use	When Stopped
Smoke								Beer						
Dip								Wine						
Chew								Liquor						
Drugs														

If you answered yes to Drug use:

Type of Drugs_____ Have you ever misused prescription drugs? ____Yes ____No

Would you be interested in quitting tobacco/ alcohol/ drug use within the next month? _____Yes _____No

When was your last

Screenings	Date	Screenings	Date	Vaccines	Date	Vaccines	Date	Vaccines	Date
Pap Smear		Colonoscopy		Flu		Pneumonia		Meningitis	
Mammogram		Prostate Exam		Hepatitis		Polio		Yellow Fever	
Bone Density		Eye Exam		Tetanus		Measles/Mumps/Rubella		Other Vaccine	

General Health

In general, would you say your health is

❒ Excellent ❒ Very Good ❒ Good ❒ Fair ❒ Poor

Sleep

Each night, how many hours of sleep do you usually get? ____ hours

Do you snore or has anyone told you that you snore? ❒ Yes ❒ No

In the past 7 days, how often have you felt sleepy during the daytime?

❒ Almost all of the time ❒ Some of the time ❒ Most of the time ❒ Almost never

Depression PHQ-9

In the past two weeks, how often have you been bothered by any of the following problems? Place a check mark over your answer	Not at all	Several Days	More than half of the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Felt 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 little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
SCORE (for office use)				
TOTAL SCORE (for office use)				
10. If you checked off any problems, how difficult have these problems 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**

Anxiety

During the past 2 weeks, how often have you felt nervous, anxious, or on edge?

❒ Almost all of the time ❒ Some of the time ❒ Most of the time ❒Almost never

During the past 2 weeks, how often were you not able to stop worrying or control your worrying?

❒ Almost all of the time ❒ Some of the time ❒ Most of the time ❒Almost never

Stress

How often is stress a problem for you in handling such things as your health, finances, family or social relationships or work?

❒ Almost all of the time ❒ Some of the time ❒ Most of the time ❒Almost never

Support

In the past 4 weeks, was someone available to help you if you needed or wanted help? (For example, if you felt nervous, lonely, or blue; got sick and needed help; needed someone to talk to, needed help with daily chores or just taking care of yourself?

❒ Almost all of the time ❒ Some of the time ❒ Most of the time ❒Almost never

Pain

During the past 4 weeks, how much bodily pain have you generally had?

❒ No pain ❒Mild Pain ❒Moderate Pain ❒Severe Pain

Functional Ability and Level of Safety

Hearing Impairment

Do you have difficulty hearing normal conversations? ❒ Yes ❒ No

Do your family members or friends complain that you are hard of hearing? ❒ Yes ❒ No

Instrumental Activities of Daily Living

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

❒ Yes ❒ No

In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, managing money, using the telephone, preparing meals, transportation, or taking your own medications?

❒ Yes ❒ No

Physical Activity

In the past 2 weeks, how many days did you exercise for 20 minutes or more? _____days

How intense was your typical exercise?

❒ Light (like stretching or slow walking) ❒ Moderate (like brisk walking)

❒ Heavy (like jogging or swimming) ❒ Very heavy (like fast running or stair climbing)

❒ I am currently not exercising

Home Safety

Do you live in _____private home ____assisted living facility ____other

Do you have working smoke detectors in your home? _____Yes ____No

Do you have working fire extinguishers in your home? ____Yes ____No

Do you have a working carbon monoxide detector in your home? ____Yes ____No

Does your home have rugs on the floor, lack grab bars in the bathroom, lack handles on the stairs, or have poor lighting?
_____Yes ___No

Has anyone tried to cause you physical harm within the last two months? ____Yes ___No

Nutrition

How many servings of fruits and vegetables do you typically eat each day? _____ servings per day

How many servings of high fiber or whole grain foods do you typically eat each day? _____ servings per day

How many servings of fried or high-fat foods do you typically eat each day? _____ servings per day

How many sugar-sweetened (not diet) beverages did you typically consume each day? _____servings per day

Advanced Directives

Do you currently have a Living Will? ❒ Yes ❒ No

Do you currently have a Durable Health Care Power of Attorney? ❒ Yes ❒ No

If you answered no, are you interested in obtaining further information about Living Wills or Durable Health Care Power of Attorney? ❒ Yes ❒ No

Are there any other health concerns you have at this time? _____

Patient Signature_____ **Date**_____