Medicare Annual Wellness Visit History Form

This is a confidential record and will be kept in your patient record. Information contained here will not be released to anyone without your authorization.

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ /_____ /_____ Age _____ Sex _____

Today's Date _____ /_____ /_____ Physician _____

Please answer the questions on this form and return it to your physician. If you don't know the answer to a question, circle the question and we will discuss it during your visit.

Your history of diseases and conditions *Have you had any of the following?*

Anemia	○ no ○ yes / *year:*	Emotional or mental illness	○ no ○ yes / *year:*	AIDS	○ no ○ yes / *year:*
Asthma	○ no ○ yes / *year:*	Emphysema	○ no ○ yes / *year:*	Kidney disease	○ no ○ yes / *year:*
Arthritis	○ no ○ yes / *year:*	Epilepsy	○ no ○ yes / *year:*	Kidney stones	○ no ○ yes / *year:*
Bleeding / blood disorder	○ no ○ yes / *year:*	Seizure	○ no ○ yes / *year:*	Liver diseases	○ no ○ yes / *year:*
Breast cancer	○ no ○ yes / *year:*	Glaucoma	○ no ○ yes / *year:*	Osteoporosis	○ no ○ yes / *year:*
Other cancer(s)	○ no ○ yes / *year:*	Hay fever	○ no ○ yes / *year:*	Physical disability	○ no ○ yes / *year:*
Cataracts	○ no ○ yes / *year:*	Heart problems	○ no ○ yes / *year:*	Rheumatic fever	○ no ○ yes / *year:*
Colitis	○ no ○ yes / *year:*	Hepatitis	○ no ○ yes / *year:*	Stroke	○ no ○ yes / *year:*
Depression	○ no ○ yes / *year:*	Jaundice	○ no ○ yes / *year:*	Thyroid disease	○ no ○ yes / *year:*
Diabetes	○ no ○ yes / *year:*	Hypertension	○ no ○ yes / *year:*	Tuberculosis	○ no ○ yes / *year:*
		HIV	○ no ○ yes / *year:*	Ulcers, gastric	○ no ○ yes / *year:*

Comments, or other problems:

Your history of surgeries and hospitalizations *Have you had any of the following?*

Appendectomy	○ no ○ yes / *year:*	Heart catheterization	○ no ○ yes / *year:*	Plastic surgery	○ no ○ yes / *year:*
Breast growth	○ no ○ yes / *year:*	Heart surgery	○ no ○ yes / *year:*	Polyp removal from intestine	○ no ○ yes / *year:*
Carpal Tunnel	○ no ○ yes / *year:*	Hernia	○ no ○ yes / *year:*	Thyroid surgery	○ no ○ yes / *year:*
Cataract surgery	○ no ○ yes / *year:*	Hip surgery	○ no ○ yes / *year:*	Tonsils or adenoids removed	○ no ○ yes / *year:*
Cesarean section	○ no ○ yes / *year:*	Hysterectomy	○ no ○ yes / *year:*	Tubal ligation	○ no ○ yes / *year:*
D and C	○ no ○ yes / *year:*	Knee surgery	○ no ○ yes / *year:*	Vasectomy	○ no ○ yes / *year:*
Gall bladder surgery	○ no ○ yes / *year:*	Nasal surgery	○ no ○ yes / *year:*	Prostate surgery	○ no ○ yes / *year:*
Gastroenteroscopy	○ no ○ yes / *year:*	Sinus surgery	○ no ○ yes / *year:*		

Comments, or other hospitalizations:

Family members' cause of death *List the cause of death for those who died* ***before age 50*** *(Do not include accidental deaths)*

Father:	Mother:
Father's Father:	Mother's Father:
Father's Mother:	Mother's Mother:

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Pt Hist 50250

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Your family's medical history

Circle if a blood relative has had each problem

Were you adopted? ○ Yes ○ No

Alcohol abuse	Father Mother	Brother Sister	Grandparent	Emotional or mental illness	Father Mother	Brother Sister	Grandparent
Other substance abuse	Father Mother	Brother Sister	Grandparent	Suicide	Father Mother	Brother Sister	Grandparent
Alzheimer's	Father Mother	Brother Sister	Grandparent	Hypertension	Father Mother	Brother Sister	Grandparent
Dementia	Father Mother	Brother Sister	Grandparent	Heart Attack	Father Mother	Brother Sister	Grandparent
Breast Cancer	Father Mother	Brother Sister	Grandparent	Osteoporosis	Father Mother	Brother Sister	Grandparent
Colon cancer	Father Mother	Brother Sister	Grandparent	Seizures	Father Mother	Brother Sister	Grandparent
Prostate cancer	Father Mother	Brother Sister	Grandparent	Stroke	Father Mother	Brother Sister	Grandparent
Cancer (other)	Father Mother	Brother Sister	Grandparent	Tuberculosis	Father Mother	Brother Sister	Grandparent
Diabetes	Father Mother	Brother Sister	Grandparent				

Your daily life

Hearing	Do you use hearing aids? ○ no ○ yes
Emotions	During the past 2 weeks, have you been feeling down, depressed, or hopeless? ○ no ○ yes / date:
	During the past 2 weeks, have you had little interest or pleasure in your usual activities? ○ no ○ yes / date:
	When you feel unwell or distressed, whom do you go to for help?
Eating	How many days a week do you eat a good breakfast?
	How many sweetened drinks do you have a day?
	How many servings of fruit and vegetables do you have a day?
	How many times a week do you eat with your family?
Physical activity	How many minutes do you exercise each time?
	How many days a week do you exercise?
	How intense is your exercise? (circle one) Light Moderate Vigorous
Safety	How often do you wear a seat belt when in a car? Always Never Sometimes None
Falls	Have you fallen in the last year? ○ no ○ yes / date:
	Are you worried you might fall? ○ no ○ yes
Immunizations	Tetanus ○ no ○ yes / *year:* Flu ○ no ○ yes / month and *year:* Pneumonia ○ no ○ yes / *year:*

Women

Have you had:

Breast self-exam ○ no ○ yes/month and *year:*	Mastectomy ○ no ○ yes / *year:* side: where done:	Mammogram ○ no ○ yes / month and *year:*

Screenings

Have you had the following screening tests? List the most recent.

Prostate ○ no ○ yes / *year:*	Glaucoma ○ no ○ yes / month and *year:*
Colonoscopy ○ no ○ yes / month and *year:*	Bone scan ○ no ○ yes / month and *year:*

Tobacco and Alcohol

Smoking or other tobacco	Never used Currently use Used to use / when did you stop?
	If using now or in the past: For how many years? How many packs a day?
Alcohol use	Never drank Currently drink Used to drink / when did you stop?
	If drinking now or in past, how often? Occasionally Daily / how many drinks per day? Binge

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