Medicare Annual Wellness Visit – History Form

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

Last Name____________________ First Name____________________ Middle Initial______

Date of Birth_____/_____/_____ EMPI #____________________ Today's Date_____/_____/_____

Name and Relationship of Person Completing Form (*if not the patient*)____________________

Your History of Diseases and Conditions *Have you had any of the following?*

☐Anemia, year______	☐Diabetes, year______	☐Kidney Disease, year______
☐Asthma, year______	☐Emotional or Mental Illness, year______	☐Kidney Stones, year______
☐Arthritis, year______	☐Epilepsy, year______	☐Liver Diseases, year______
☐Bleeding or Blood Disorder, year______	☐Seizure, year______	☐Osteoporosis, year______
☐Breast Cancer, year______	☐Glaucoma, year______	☐Physical Disability, year______
☐Other Cancer(s) , year______	☐Hay Fever, year______	☐Rheumatic Fever, year______
☐Cataracts, year______	☐Heart Problems, year______	☐Stroke, year______
☐Colitis, year______	☐Hepatitis or Jaundice, year______	☐Thyroid Disease, year______
☐COPD or Emphysema, year______	☐Hypertension, year______	☐Tuberculosis, year______
☐Depression, year______	☐HIV / AIDS, year______	☐Ulcers, Gastric, year______
Comments or Other Problems:		

Your History of Surgeries and Hospitalizations *Have you had any of the following?*

☐Appendectomy, year______	☐Heart Catheterization, year______	☐Sinus Surgery, year______
☐Breast Growth, year______	☐Heart Surgery, year______	☐Plastic Surgery, year______
☐Carpal Tunnel, year______	☐Hernia, year______	☐Polyp Removal from Intestine, year______
☐Cataract Surgery, year______	☐Hip Surgery, year______	☐Thyroid Surgery, year______
☐Cesarean Section, year______	☐Hysterectomy, year______	☐Tonsils or Adenoids Removed, year______
☐D and C, year______	☐Knee Surgery, year______	☐Tubal Ligation, year______
☐Gall Bladder Surgery, year______	☐Mastectomy, year______ Side: ☐L ☐R	☐Vasectomy, year______
☐Gastroenteroscopy, year______	☐Nasal Surgery, year______	☐Prostate Surgery, year______
Comments or Other Hospitalizations:		

Screenings *Have you had the following screening tests?*

Colonoscopy	☐No	☐Yes, month and year of most recent:__________
Eye Exam	☐No	☐Yes, month and year of most recent:__________
Bone Density	☐No	☐Yes, month and year of most recent:__________
Mammogram (women)	☐No	☐Yes, month and year of most recent:__________
Pelvic Exam (women)	☐No	☐Yes, month and year of most recent:__________
Prostate (men)	☐No	☐Yes, month and year of most recent:__________

 ©IHC Health Services, Inc. (2012)

Intermountain® Healthcare

Vaccines *Have you received the following vaccines?*

Flu (Influenza)	☐No	☐Yes, month and year of most recent:________________
Pneumonia/Pneumococcal (Pneumovax)	☐No	☐Yes, month and year of most recent:________________
Pneumonia/Pneumococcal (Prevnar 13)	☐No	☐Yes, month and year of most recent:________________
Shingles (Herpes Zoster)	☐No	☐Yes, month and year of most recent:________________
Tetanus, Diphtheria, Pertussis (Tdap)	☐No	☐Yes, month and year of most recent:________________

Tobacco and Alcohol

Smoking, Other Tobacco, or Nicotine-Containing Products	☐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 the past: How often? ☐Occasionally ☐Daily—How many drinks per day?________ ☐Binge		

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

Your Family's Medical History *Check the box if a blood relative has had any of the following problems.*

Were you adopted?	☐Yes	☐No					
Alcohol Abuse	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Other Substance Abuse	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Alzheimer's or Dementia	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Breast Cancer	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Colon Cancer	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Prostate Cancer	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Other Cancer(s)	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Diabetes	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Emotional or Mental Illness	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Suicide	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Hypertension	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Heart Attack Prior to Age 55	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Osteoporosis	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Seizures	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle
Stroke	☐Father	☐Mother	☐Brother	☐Sister	☐Grandparent	☐Aunt	☐Uncle

Please check any conditions which are significant problems to you

General
☐Recent 10+ lb weight change
☐Frequent fevers
☐Frequent profound fatigue
☐Frequent difficulty sleeping
☐Received a blood transfusion in past year

Head and Neck
☐Visual changes (not glasses)
☐Dizziness
☐Double vision
☐Sinus problems
☐Nosebleeds
☐Ear pain
☐Trouble hearing
☐Ringing in the ear
☐Hoarseness
☐Persistent sore throat
☐Mouth sores
☐Frequent swollen glands

Respiratory / Lungs
☐Persistent cough
☐Shortness of breath
☐Coughing up blood
☐Wheezing
☐Stopping breathing during sleep

Heart / Vascular
☐Chest pain or tightness
☐Irregular rapid heart beat
☐Smothering feeling at night
☐Ankle swelling

Stomach / Bowel
☐Major appetite change
☐Frequent nausea or vomiting
☐Frequent heartburn or acid in throat (GERD)
☐Abdominal pain
☐Frequent diarrhea
☐Constipation
☐Black or bloody stools
☐Vomiting blood
☐Difficulty swallowing

Kidney / Bladder
☐Kidney or bladder infection
☐Problems with bladder control
☐Difficulty starting urination
☐Frequent urination
☐Increased urgency
☐Urination more than once nightly
☐Burning or painful urination
☐Blood in the urine
☐Difficulty emptying bladder

Reproduction
☐Blood in semen / sperm (*men*)
☐Inability to have an erection (*men*)
☐Inability to reach climax
☐Infertility
☐Painful intercourse
☐Decreased sexual desire
☐Sexually transmitted diseases

Women's Health
☐Breast pain or lumps
☐Pelvic pain
☐Vaginal discharge
☐Vaginal dryness
☐Frequent sweats or hot flashes
☐Menstrual problems
☐Menopause
☐Pregnancy problems
☐Baby weighing 9 lbs or more

Skeletal
☐Major joint pain
☐Major back pain
☐Major neck pain
☐Weakness in arms or legs
☐Joint stiffness or swelling
☐Deformities of the back or extremities
☐Gout

Neuro
☐Numbness or tingling
☐*Severe* frequent headaches
☐Abnormal coordination
☐Trouble with speech
☐Forgetfulness or confusion

Skin and Hair Problems
☐Major changes in hair or hair loss
☐Wounds that will not heal
☐Persistent rash
☐Change in moles
☐Major skin problems

Psychological / Social
☐Feeling blue or discouraged
☐High anxiety or stress
☐Loss of friends
☐Feeling life has no purpose
☐Feeling others are talking about you
☐Feeling fear
☐Hearing voices
☐Marital or relationship problems
☐Early morning awakenings

Reviewed by Clinician: Clinician Signature________________________ Date__________ Time______

 ©IHC Health Services, Inc. (2012)

Intermountain® Healthcare

Medicare Annual Wellness Visit – Health Risk Form

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

Last Name____________________ First Name____________________ Middle Initial____

Date of Birth_____/_____/_____ EMPI #____________________ Today's Date_____/_____/_____

Name and Relationship of Person Completing Form (*if not the patient*)______________________________

Please complete this form before seeing your doctor or healthcare team. Your responses will help you receive the best health and health care possible.

1	In the past two weeks, have you been feeling down, depressed, or hopeless?	☐No	☐Yes
2	During the past two weeks, have you had little interest or pleasure in your usual activities?	☐No	☐Yes
3	Are there hazards in your house that might hurt you?	☐No	☐Yes
4	Have you fallen in the past year?	☐No	☐Yes
5	Are you worried you might fall?	☐No	☐Yes
6	Do you use a cane or walker?	☐No	☐Yes
7	Do you need someone to help you get up in the morning?	☐No	☐Yes
8	In the past four weeks, have you fallen or felt dizzy when standing up?	☐No	☐Yes
9	Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?	☐No	☐Yes
10	Do you have trouble consistently taking or remembering to take all of your medications as prescribed?	☐No	☐Yes
11	During the past four weeks, have you had pain present? If yes, primary location of pain____________________ Average pain score 0 -10, with 0 being none and 10 being worst pain in your life__________	☐No	☐Yes

12	Can you get to places out of walking distance without help (for example, can you travel alone on buses or taxis, or drive your own car?	☐Yes	☐No
13	Can you go shopping for groceries or clothes without someone's help?	☐Yes	☐No
14	Can you prepare your own meals?	☐Yes	☐No
15	Can you do your housework without help?	☐Yes	☐No
16	Can you handle your own money without help?	☐Yes	☐No
17	Can you keep track of your own medications without help?	☐Yes	☐No

 ©IHC Health Services, Inc. (2012)

Intermountain® Healthcare

18	How have things been going for you during the past four weeks? ☐Very well ☐Pretty well ☐Good and bad parts about equal ☐Pretty bad ☐Very bad

19	During the past four weeks, how would you rate your health in general? ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

20	During the past four weeks, was someone available to help you if you needed and wanted help? ☐Yes, as much as I wanted ☐Yes, quite a bit ☐Yes, some ☐Yes, a little ☐No, not at all

21	During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups? ☐Not at all ☐Slightly ☐Moderately ☐Quite a bit ☐Extremely

22	During the past four weeks, how often have you been *bothered* by any of the following problems?					
	Sexual problems	☐Never	☐Seldom	☐Sometimes	☐Often	☐Always
	Trouble eating well	☐Never	☐Seldom	☐Sometimes	☐Often	☐Always
	Teeth or denture problems	☐Never	☐Seldom	☐Sometimes	☐Often	☐Always
	Problems using the telephone	☐Never	☐Seldom	☐Sometimes	☐Often	☐Always

23	How confident are you that you can control and manage most of your health problems? ☐I do not have any health problems ☐Very confident ☐Somewhat confident ☐Not very confident

24	Are you having difficulties driving your car? ☐Not applicable, I do not use a car ☐No ☐Sometimes ☐Yes, often

25	Do you fasten your seat belt when you are in a car? ☐I always fasten my seat belt ☐I occasionally fasten my seat belt ☐I never fasten my seat belt

26	Please list the names of your medical providers, medical equipment suppliers, etc.____________________

Reviewed by Clinician: Clinician Signature________________________ Date____________ Time______

 ©IHC Health Services, Inc. (2012)

Intermountain® Healthcare