New Providence Internal Medicine Associates

MEDICARE WELLNESS VISIT

(WELLNESS VISIT DOES NOT INCLUDE TREATMENT OF NEW OR ONGOING PROBLEMS)

Your name: _____ Date of physical: _____

Doctor you are seeing: _____ Date of birth: _____ Your age: _____

Please list all medications, supplements, vitamins, etc., and list all other doctors who are treating you. Fee l free to use additional sheets if needed.

Name	dosage	When do you take it	comments

Please list any other doctors who are currently treating you: _____

ONLY COMPLETE ANY SECTION BELOW WHICH HAS CHANGED SINCE YOUR LAST PHYSICAL:

1. Ongoing health problems: _____
2. Past health problems: _____
3. Past surgeries: _____
4. Hospitalizations, not for surgical problems: _____
5. Allergies to medications: _____
6. Family history: (list health problems, especially cardiovascular and cancers):

	Age (or year of birth) (if living)	Age when deceased	Health problems and conditions
Father			
mother			
sibling			
sibling			

7. Do you drink alcohol? If yes, how many drinks per week (one drink is 2 ounces of hard liquor, 5 ounces of wine, or 12 ounces of beer): _____
8. Do you currently smoke cigarettes: _____ if yes, how many packs per day? _____ At what age did you start smoking? _____ If you smoked in the past, at what age did you start? _____ At what age did you stop? _____ How many packs a day had you smoked? _____
9. Are you on a special diet (e.g. vegetarian, gluten free, etc.)? _____
10. Do you have a living will or advanced directive? _____
11. What type of regular exercise do you do? _____
12. What type of work do you do?_____ How many hours a week do you work? _____
13. What is your marital status: _____ How many children do you have? _____
14. Do you wear seatbelts when you drive or are a passenger?_____
15. Have you ever used intravenous drugs in the past? _____

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16. How would you describe your health overall?_____
17. Are you: heterosexual, homosexual, bisexual? (circle one)

Please do answer all the questions below:

- How many times have you fallen over the past year?: _____
- Any change in memory, forgetfulness, or judgement?: _____
- How many hours do you sleep at night? _____ ; Has anyone ever noticed if you stop breathing overnight while you are sleeping? _____

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

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Date of Last General Screening:
• Mammogram
• Pap test
• Bone Density (DEXA)
• Colonoscopy
• Stool test for blood (hemoccult)
List the date of Last Immunizations:
• Influenza (flu shot)
• pneumonia
• Tetanus/Adacel
• Shingles/Zostavax

Any other questions or issues to discuss with the doctor?

Name: _____