Welcome to Medicare Patient History Form

Name: DOB: Appointment:

In the past year have you had any injuries, visits to urgent care or ER, hospital admissions or surgeries?

Date	Facility	Reason

What vitamins, minerals, supplements, herbs and Over the Counter (OTC) medications do you take?
Are there any new medications prescribed by doctors outside The Doctors Clinic?

Name	Dose	Frequency		**Name**	Dose	Frequency

I am currently: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed

Advanced Health Care and End of Life Planning
I currently have:

End of Life Decisions Yes No
Health Power of Attorney Yes No
Living Will Yes No

<u>My Health History</u>

☐ ***In the past year my health has not changed.*** **OR**

☐ ***In the past year*** *I have received a* ***<u>new</u>*** *diagnosis of: Check all that apply.*

____ High Blood Pressure
____ Coronary artery disease
____ Disorder of the Heart or Heart disease
Type:
____ Any disease of the stomach, intestines, liver or kidneys
____ Any neurological disease

____ Diabetes
____ COPD (Emphysema)
____ Cancer
Type:
____ Aneurysm of any blood vessel
____ Stroke or TIA's

____ Depression or other mood disorder ____ Other:________________________

My Health Assessment for the Past 12 Months

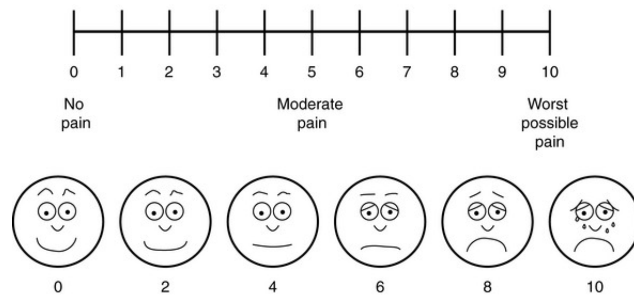
1. I have felt my health to be

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Excellent

2. I have pain that regularly interferes with my daily routine/activity

- ☐ Yes
- ☐ No
- ☐ Sometimes

2a. If you have pain please rate using the numbers or faces



3. I have had changes in my hearing

- ☐ Yes
- ☐ No
- ☐ I wear hearing aids

4. I am able to perform routine household tasks

- ☐ Yes
- ☐ No
- ☐ Sometimes

5. I am confident I am able to manage my health and medications

- ☐ Yes
- ☐ No
- ☐ Sometimes

6. I am concerned about my independence and have trouble shopping, managing finances, keeping appointments

- ☐ Yes
- ☐ No
- ☐ Sometimes

7. I have difficulty dressing and bathing myself

- ☐ Yes
- ☐ No
- ☐ Sometimes

8. I experience urinary incontinence

- ☐ Yes
- ☐ No
- ☐ Sometimes

9. I perform physical activity at least 30 minutes

- ☐ Every day
- ☐ Several times a week
- ☐ Never
- ☐ I feel I am unable to be active

10. My physical activity intensity is:

- ☐ Light (stretching, walking)
- ☐ Moderate (brisk walking, vacuuming)
- ☐ Heavy (dancing, swimming, yard work)
- ☐ A planned exercise regimen

11. I am able to drive my car

- ☐ Yes
- ☐ No
- ☐ I don't drive

12. I sleep soundly at night

- ☐ Yes
- ☐ No
- ☐ Sometimes

13. I currently drink alcohol

- ☐ Never
- ☐ Occasionally, socially
- ☐ Every day
- ☐ More than I should

14. I am:

- ☐ A current smoker
- ☐ A former smoker
- ☐ A never smoker
- ☐ I have been exposed to second hand smoke

15. Food I may eat too often includes:

- ☐ Fried foods
- ☐ White flour products
- ☐ Sugary, snack foods
- ☐ Fast food

16. Generally my food is:

- ☐ Prepackaged meals
- ☐ Made from scratch
- ☐ Brought to me or prepared by someone outside my residence

17. I am interested in discussing weight management with the nurse:

- ☐ Yes
- ☐ No

18. My memory:

- ☐ concerns me
- ☐ is frustrating but I'm not concerned
- ☐ I have no concerns

19. My sense of smell is:

- ☐ Good
- ☐ Not as good as it used to be
- ☐ Poor, I don't smell much

20. I seem to have lost my sense of direction or get lost in familiar places.

- ☐ Yes
- ☐ No

21. I feel mistreated or taken advantage of by others

- ☐ Yes
- ☐ No
- ☐ Sometimes

22. I feel safe where I live

- ☐ Yes
- ☐ No
- ☐ Usually

23. I have had a major life change in the last year

- ☐ Yes
- ☐ No

24. I have concerns about my health

- ☐ Yes
- ☐ No
- ☐ Sometimes

25. Have you fallen in the past 12 months? No Yes

If yes how many times? Did you have any injury? No Yes

Do you worry about falling? No Yes

Do you ever feel unsteady when walking or stepping up onto curbs/steps? No Yes

Do you have any numbness in your legs or feet? No Yes

Do any of your medications make you fell light headed, dizzy or tired? No Yes

Circle items you have in your home: Scatter/throw rugs Grab bars Night lights Electric space heater

		Circle your response		
Over the last **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
little interest in doing things	0	1	2	3
feeling down, depressed or hopeless	0	1	2	3
trouble falling or staying asleep or sleeping too much	0	1	2	3
feeling tired and had little energy	0	1	2	3
poor appetite or have been overeating	0	1	2	3
feeling bad about myself or felt that I let myself or my family down	0	1	2	3
trouble concentrating on TV or reading	0	1	2	3
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
thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problem on this questionnaire so far, how difficult have these 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

Form completion by: Myself A family member A caregiver

Signature of person completing form____

Provider Reviewed:

RN co-sign