Medicare Wellness Form
Patient History & Health Risk Assessment

EVMS MEDICAL GROUP
The knowledge to treat you better

This **Medicare Total Health Assessment** is part of your upcoming Annual Wellness Visit. Please answer the following questions about your health and day-to-day activities. This questionnaire will help your clinical team address the areas important to your overall well-being. This questionnaire should take about 10-20 minutes to complete. If you need help, please contact the medical staff or ask for help during your visit. Thank you.

Name: _____ Age: _____ Date: _____

1. **Please list any SPECIALISTS you see, approximately when you last saw them, and how often you visit.**

Doctor Name & Specialty	Date Last Seen	How often do you see them? Check the correct box		
		Yearly	Every 6 months	As Needed
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

2. **Have you had any hospitalizations or visits to the Emergency Room in the last 6 months:** ☐ Yes ☐ No

If yes, please fill in the information below:

Date	Name of the hospital	Reason for admission or ER Visit

3. **Family- Medical History.** Please check the box that applies:

Medical Problem/Illness	I have/had this problem	Family member Please list relationship
Alzheimer's / Dementia	☐	
Asthma	☐	
Cancer: circle one Breast | colon | lung | ovarian | prostate | skin | other_____	☐	
Chronic Obstructive Pulmonary Disease (Emphysema or Chronic Bronchitis)	☐	
Congestive Heart Failure	☐	
Coronary heart disease/ heart attack/ angina	☐	
Depression	☐	
Diabetes Mellitus	☐	
High Blood Pressure	☐	
High cholesterol	☐	
Renal (Kidney) Disorder	☐	

4. **Health Screenings:** Name_____ Birth date_____

When was the last time you:	Date Completed & Where
had your eyes examined	
saw a dentist	
had a colonoscopy or at home stool test	
had a bone density test	
had a mammogram	
had a pap smear	
had a screening for abdominal aorta aneurysm (males)	
have you ever been screened for Hepatitis or HIV?	

5. **Immunization History:**

Immunization	Date & where you went to get it
Influenza Yearly vaccine	
Pneumovax Done after the age of 65 to prevent pneumococcal infection	
Prevnar Done after the age of 65 to prevent pneumococcal infection	
Tetanus Known as Td or DTaP- recommended every 10 years	
Zostavax Prevent or lessen an outbreak of shingles	
Any other immunizations Hepatitis A, Hepatitis B, or immunizations needed for travel: List: _____	

Overall Health

6. In general, compared to other people your age, would you say that your health is:

☐ Excellent ☐ Fair
☐ Very Good ☐ Poor
☐ Good

7. Compared to last year, how would you rate your overall health?

☐ Better ☐ Worse
☐ About the same

8. How confident are you that you can manage most of your health problems?

☐ Very confident ☐ Somewhat confident ☐ Not very confident
☐ I do not have any health problems

9. Have you had any unintentional weight loss or gain in the past 6 months? ☐ Yes ☐ No

Stress/Emotions

10. Do you have a history of depression? ☐ Yes ☐ No

	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	☐	☐	☐	☐
2	Feeling down, depressed, or hopeless	☐	☐	☐	☐

11. How often do you get the social and emotional support you need?

☐ Always ☐ Rarely
☐ Usually ☐ Never
☐ Sometimes

Lifestyle/habits Name_____ Birth date_____

12. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?

☐ 10 or more drinks per week ☐ One drink or less per week
☐ 6-9 drinks per week ☐ No alcohol at all
☐ 2-5 drinks per week

13. In the last 30 days, have you used tobacco?

Smoked: ☐ Yes ☐ No
Used a smokeless tobacco product: ☐ Yes ☐ No
If yes to either, would you be interested in quitting tobacco use within the next month? ☐ Yes ☐ No

14. Tobacco Smoking History:

☐ Never a smoker ☐ Current Every Day Smoker
☐ Former Smoker ☐ Current Some Day Smoker

15. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

☐ Never ☐ Weekly
☐ Once or Twice ☐ Daily or almost daily
☐ Monthly

16. Do you exercise for about 20 minutes three or more days a week?

☐ Yes, most of the time ☐ No, I usually do not exercise this much
☐ Yes, some of the time

17. How often do you eat food that is healthy (fresh fruits, fish and vegetables) instead of unhealthy food (fried foods, sweets and "junk food")?

In the last week my evening meals were:
☐ Almost always healthy ☐ A little of the time healthy
☐ Most of the time healthy ☐ Almost never healthy
☐ Some of the time healthy

18. In the past 7 days, how many sugar-sweetened (not diet) beverages did you consume each day

_____ sugar sweetened beverages consumed per day

19. Do you SNORE or has anyone told you that you snore? ☐ Yes ☐ No

20. Do you often feel tired, or sleepy during the daytime? ☐ Yes ☐ No

Activities/Function

21. 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, help with _____
☐ No

22. In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

☐ Yes, help with _____
☐ No

23. During the past four weeks, was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself)

☐ Yes, as much as I wanted ☐ No, not at all
☐ Yes, some

Symptoms Name_____ Birth date_____

24. How often during the PAST FOUR WEEKS have you been bothered by any of the following problems?

Problem	Never	Sometimes	Often
Dizzy when standing up	☐	☐	☐
Sexual problems	☐	☐	☐
Hearing Problems	☐	☐	☐
Mouth, Teeth or denture problems	☐	☐	☐
Difficulty with daily activities because of eyesight?	☐	☐	☐
Trouble urinating or wetting	☐	☐	☐
Trouble thinking or remembering	☐	☐	☐
Significant pain	☐	☐	☐

Safety /Barriers

25. Do you always fasten your seat belt when you are in a car? ☐ Yes, usually ☐ No, not usually

26. Have you fallen two or more times in the past year (a fall is when your body goes to the ground without being pushed)?

☐ Yes ☐ No

27. Have you had a fall that caused an injury in the past year? ☐ Yes ☐ No

28. Do you feel unsteady when standing or walking? ☐ Yes ☐ No

Do you worry about falling? ☐ Yes ☐ No

30. How often do you have trouble taking medicines the way you have been told to take them?

☐ I do not have to take medicine ☐ Sometimes I take them as prescribed
☐ I always take them as prescribed ☐ I seldom take them as prescribed

31. Do you understand your medications and what you are taking them for? ☐ Yes ☐ No

32. Do you find that you sometimes have to choose between buying groceries or medications? ☐ Yes ☐ No

33. Problems with medication include: _____

_____

End of Life Planning

34. Do you have any advance directives for your health care (for example, medical Durable Power of Attorney, Living Will, Five Wishes, CPR or Do Not Resuscitate directive)?

☐ Yes ☐ No

If yes, please bring copy of your document to visit

35. Who completed this survey form? ☐ Myself ☐ Relative ☐ Friend ☐ Caregiver

36. The healthy change that I would like to make is:

☐ Improve my diabetes ☐ eat healthier
☐ improve my blood pressure ☐ _____
☐ lose weight