Patient History Form

DATE_____/_____/_____

Patient Name_____ Age _____ Date of Birth _____/_____/_____ MRN #_____

As part of your Medicare **Annual Wellness Visit,** please complete the following questionnaire to the best of your ability. It is an important and confidential part of your medical record.

Please list all of your Medical Providers and Suppliers involved in your care:

Please List All Current Medications and Supplements (include over-the-counter & prescription medicine)**:**

Please list any hospitalizations or surgeries you have undergone and the year performed:

Hospitalization / Surgery	**Year**

Do you smoke cigarettes?
☐ No ☐ Yes; how many packs per day? ___

Do you drink alcohol?
☐ No ☐ Yes; how many drinks per day? ___

Have you used drugs for recreation?
☐ No ☐ Yes; what type and when?
_____
_____

Have you or others in your immediate family (parents, grandparents, brothers, sisters, children or grandchildren) had any of the following? (Please check all that apply.)

	Self	**Family Member** (list relation)		**Self**	**Family Member** (list relation)		**Self**	**Family Member** (list relation)
General:			**Respiratory:**			**Neurologic:**		
Cancer: Breast	☐	☐	Asthma	☐	☐	Nerve Impairment	☐	☐
Cancer: Colon	☐	☐	Lung disease	☐	☐	Seizure disorder	☐	☐
Cancer: _____	☐	☐	Tuberculosis	☐	☐	Stroke	☐	☐
Weight loss/gain	☐	☐	Pneumonia	☐	☐		☐	☐
	☐	☐	Pleurisy	☐	☐	**Psychiatric:**		
Head:				☐	☐	Alcoholism	☐	☐
Trauma	☐	☐	**Gastrointestinal:**			Anxiety	☐	☐
Concussion	☐	☐	Colitis	☐	☐	Depression	☐	☐
	☐	☐	Diverticulitis	☐	☐	Mental illness	☐	☐
Eyes:			GERD	☐	☐	Phobias	☐	☐
Glaucoma	☐	☐	GI Bleed	☐	☐		☐	☐
Macular degeneration	☐	☐	Liver disease	☐	☐	**Endocrine:**		
	☐	☐	Stomach Ulcer	☐	☐	Diabetes	☐	☐
Ears, Nose, Mouth & Throat				☐	☐	Thyroid disease	☐	☐
Hearing loss	☐	☐	**Genitourinary:**				☐	☐
Vertigo	☐	☐	Enlarged Prostate	☐	☐	**Hematologic:**		
	☐	☐	Kidney Disease	☐	☐	Anemia	☐	☐
Cardiovascular:			Urinary Infection	☐	☐	Blood disorder	☐	☐
Congestive Heart Failure	☐	☐		☐	☐	**Immunologic:**		
Coronary Artery Disease	☐	☐	**Musculoskeletal:**			HIV	☐	☐
Heart disease	☐	☐	Arthritis	☐	☐	**Please list any other condition below:**		
High cholesterol	☐	☐	Fracture	☐	☐		☐	☐
Hypertension	☐	☐	Osteoporosis	☐	☐		☐	☐
Heart murmur	☐	☐					☐	☐
Heart arrhythmia	☐	☐	**Skin:**	☐	☐		☐	☐
Vascular disease	☐	☐	Eczema	☐	☐		☐	☐
	☐	☐	Psoriasis	☐	☐		☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Patient Signature: _____ Provider Signature: _____

Atrium Health

Annual Wellness Visit Pre-Visit Patient Information

Clinical teammate must manually enter the information or scan the form into Canopy

Patient Name: _____ MRN: _____ DOB: _____

Health Risk Assessment

Can you afford your medications?	☐ NO	☐ YES
Do you have difficulty refilling your medications?	☐ NO	☐ YES
Do you have trouble consistently taking or remembering to take all of your medications as prescribed?	☐ NO	☐ YES
Do you use opioid medication? Specify type: _____	☐ NO	☐ YES
Do you have any hearing difficulty or require hearing aids?	☐ NO	☐ YES
Can you go shopping for groceries or clothes without help?	☐ NO	☐ YES
Can you do housekeeping without help?	☐ NO	☐ YES
Can you prepare your own meals?	☐ NO	☐ YES
Can you manage your own money without help?	☐ NO	☐ YES

How would you rate your general health?

☐ Excellent ☐ Fair
☐ Very Good ☐ Poor
☐ Good

Is someone available to help you if you needed and wanted help?

☐ Yes, as much as I need
☐ Yes, quite a bit
☐ Yes, some
☐ Yes, a little
☐ No not at all

Has your physical and emotional health limited your social activities with family, friends neighbors or groups?

☐ Not at all ☐ Quite a bit
☐ Slightly ☐ Extremely
☐ Moderately

How often have you had trouble eating well?

☐ Never ☐ Often
☐ Seldom ☐ Always
☐ Sometimes

Patient Name: _____ MRN: _____ DOB: _____

How often have you had teeth or denture problems?

☐ Never ☐ Often
☐ Seldom ☐ Always
☐ Sometimes

How often have you had problems using the telephone?

☐ Never ☐ Often
☐ Seldom ☐ Always
☐ Sometimes

How often have you been bothered by sexual problems?

☐ Never ☐ Often
☐ Seldom ☐ Always
☐ Sometimes

Are you having difficulties driving your vehicle?

☐ I no longer drive
☐ I don't have any driving issues
☐ Sometimes I have driving issues _____
☐ Yes, I often have driving issues

Do you always wear your seat belt when you are in a vehicle?

☐ I always fasten my seat belt
☐ I occasionally fasten my seat belt
☐ I never fasten my seat belt

Functional Assessment

Please check any of the following activities if you require assistance.

Activity	Requires assistance	Comment
Bathing		
Dressing		
Toileting		
Transferring bed or chair		
Continence		
Feeding		
Mobility (walking, stairs, etc.)		

Patient Name: _____ MRN: _____ DOB: _____

Home Safety Screening

Are emergency numbers kept by the phone and regularly updated?	☐ Yes	☐ No	☐ N/A
Are firearms stored unloaded and securely locked?	☐ Yes	☐ No	☐ N/A
Do all stairways have a railing or banister?	☐ Yes	☐ No	☐ N/A
Are all household members aware of the dangers of smoking, especially in bed?	☐ Yes	☐ No	☐ N/A
Are working smoke alarms, carbon monoxide detectors and fire extinguishers available for use?	☐ Yes	☐ No	☐ N/A
Do all household members know how to use smoke alarms, carbon monoxide detectors and fire extinguishers?	☐ Yes	☐ No	☐ N/A
Have throw rugs been removed or fastened down?	☐ Yes	☐ No	☐ N/A
Are non-slip mats in all bathtubs and showers?	☐ Yes	☐ No	☐ N/A
Do bathtubs and showers have at least one grab bar?	☐ Yes	☐ No	☐ N/A
Are doorways, halls, and stairs free of clutter?	☐ Yes	☐ No	☐ N/A
Are sidewalks and all outdoor steps clear of tools, toys and other articles?	☐ Yes	☐ No	☐ N/A
Are all electrical cords in working order, easily seen and not running under rugs/carpets or wrapped around nails?	☐ Yes	☐ No	☐ N/A

Family History

Please add any new Family History information below.

Family Member	Disease/Condition

Patient Communications

Please list all of your medical providers and suppliers involved in your care.

Providers of Record	Practice/Specialty