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.