# AWV / IPPE

## Patient History Form

DATE ____/____/____

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

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

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

| Hospitalization / Surgery | Year | Hospitalization / Surgery | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Marital Status?** _____ **Children?** ☐ No ☐ Yes: Ages: _____

**Have you ever smoked?** ☐ No ☐ Yes: how many packs per day? ____

**Quit?** ☐ No ☐ Yes: date ___/___/___

**Do you drink alcohol?** ☐ No ☐ Yes: how many drinks per day? ____

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

**Level of physical activity?** ☐ Limited ☐ Moderate ☐ Highly active **Do you follow a particular diet?** ☐ No ☐ Yes

**Do you currently suffer from or 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.

# ADDITIONAL PATIENT HISTORY FORM

Please list all current medications and supplements (over-the-counter and prescription):

| MEDICATION/SUPPLEMENT | DOSAGE | USAGE |
|---|---|---|
| | | |
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| | | |
| | | |
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| | | |

Allergies/Intolerances:

| DRUG/SUBSTANCE | REACTION |
|---|---|
| | |
| | |
| | |
| | |
| | |

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Additional miscellaneous information about your health:

Provider Signature: _____ Date: _____

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# Functional Abilities / Depression Questionnaire

**Patient Name:** _____ **Date:** _____

**Functional Abilities Assessment**: Please indicate (✓) if you require assistance with any of the following activities.

- [ ] Eating
- [ ] Bathing
- [ ] Dressing
- [ ] Grooming
- [ ] Going to the toilet
- [ ] Preparing meals
- [ ] Housework
- [ ] Shopping
- [ ] Climbing stairs
- [ ] Communicating with others
- [ ] Moving in and out of bed or chairs
- [ ] Following a prescribed drug regimen
- [ ] Driving or accessing transportation services

Please select (✓) the best answer for each of the following questions about home safety.

| Yes | No | |
|---|---|---|
| | | Do you have any hearing difficulty or require hearing aid(s)? |
| | | Are lamp, extension and telephone cords placed out of the flow of traffic? |
| | | Are cords in good condition, out from under rugs and furniture? |
| | | Do extension cords always carry their proper load? |
| | | Are all small rugs and runners slip resistant? |
| | | Are emergency numbers posted on or near telephones? |
| | | Could you access a telephone should you experience a fall that prevents you from standing? |
| | | Are all smoke detectors properly placed and in good working order? |
| | | Are all small stoves and heaters placed where they cannot be knocked over and away from furnishings (furniture, curtains, rugs, etc.)? |
| | | Is wood burning equipment installed properly? |
| | | Do you have an emergency exit plan and alternate exit plan in case of fire? |
| | | Are towels, curtains, and other things that might catch fire located away from the range? |

| Yes | No | |
|---|---|---|
| | | Are all extension cords and appliance cords located away from the sink or range areas? |
| | | Are hallways, passageways between rooms, and other heavy traffic areas well lit? |
| | | Are exits and passageways kept clear? |
| | | Are bathtubs and showers equipped with non-skid mats, abrasive strips, or surfaces that are not slippery? |
| | | Do bathtubs and showers have at least one (preferably two) grab bars? |
| | | Are all medicines stored in the containers that they came in and are they clearly marked? |
| | | Is a lamp or light switch within reach of your bed? |
| | | Are ash trays, smoking materials or other fire sources (heaters, hot plates, teapots, etc.) located away from beds or bedding? |
| | | Are heating pads always turned off before going to sleep? |
| | | Is there a telephone close to your bed? |
| | | Are stairs well lighted? |
| | | Do the stair steps allow for secure footing? |

**Depression Assessment:** For each of the following questions, please select (✓) the answer that best represents how you have felt over the past week.

| Yes | No | |
|---|---|---|
| | | Have you dropped many of your activities of interest |
| | | Do you feel that your life is empty? |
| | | Do you often get bored? |
| | | Are you afraid that something bad is going to happen to you? |
| | | Do you often feel helpless? |
| | | Do you prefer to stay home, rather than going out and doing new things? |
| | | Do you feel you have more problems with memory than most? |
| | | Do you feel pretty worthless the way you are right now? |

| Yes | No | |
|---|---|---|
| | | Do you feel that your situation is hopeless? |
| | | Do you think most people are better off than you are? |
| | | Are you basically satisfied with your life? |
| | | Are you in good spirits most of the time? |
| | | Do you feel happy most of the time? |
| | | Do you think it is wonderful to be alive? |
| | | Do you feel full of energy? |

**Physician Signature:**

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# *HIPAA* Authorization Form*

Patient Name: _____ DOB: _____

Do you agree to share information (lab results, medication requests, appointments, billing information, etc.) with anyone?

☐ No, I do not wish to share any information

☐ Yes (please fill in additional information)

| Contact Name | Contact Number | Relationship | Comments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Signature: _____ Date: _____

Printed Name (if other than the patient): _____

Relationship: _____

** Health Insurance Portability and Accountability Act of 1996*