EFFINGHAM PromptCare Primary & Urgent Care

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MEDICARE ANNUAL WELLNESS FORM

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Date of Birth:

INJURIES & TREATMENTS

Date:	Injury Description:	Doctor:

HOSPITALIZATIONS

Date:	Reason:	Doctor/Hospital:

SURGICAL HISTORY (INCLUDE SURGERIES FROM CHILDHOOD)

Type of Surgery:	Date of Surgery:	Surgeon/Location:

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MEDICATIONS

Medications: List any medications you are currently taking (please include over the counter medications):

Medication Name:	Medication Dosage:	Prescribing Doctor:

FAMILY HISTORY

Please indicate if any of your relatives have had any of the following by placing an X in the appropriate box.

Cancer: ☐ Maternal ☐ Paternal **Notes:**

Diabetes: ☐ Maternal ☐ Paternal **Notes:**

Heart Problems: ☐ Maternal ☐ Paternal **Notes:**

Hypertension: ☐ Maternal ☐ Paternal **Notes:**

Stroke: ☐ Maternal ☐ Paternal **Notes:**

Other: ☐ Maternal ☐ Paternal **Notes:**

Other: ☐ Maternal ☐ Paternal **Notes:**

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ADDITIONAL PROVIDERS

List all other providers/specialists you see including dental and vision:

Provider Name & Location:	Specialty:

ACTIVITIES OF DAILY LIVING

Please answer the questions below by marking the applicable column:

Bathing:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Dressing:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Grooming:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Oral Care:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Toileting:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Transferring:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Walking:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Stairs:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Eating:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Shopping:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Cooking:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Medication:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Using a Phone:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Housework:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Laundry:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Driving:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable
Managing Money:	☐ Requires No Assistance	☐ Some Assistance Needed	☐ Complete Assistance Needed	☐ Not Applicable

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HEALTH & SAFETY QUESTIONS

How many times a day do you brush/floss your teeth?

How often do you see a dentist? (Per Year)

Do you always fasten your seat belt when you are in a car? ☐ Yes ☐ No

Do you ever drive after drinking, or ride with a driver who has been drinking? ☐ Yes ☐ No

Do you protect yourself from the sun when you are outdoors? ☐ Yes ☐ No

Does your home have rugs in the hallway, lack of grab bars, lack of handrails, or poor lighting? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No **Does your home have smoke alarms?** ☐ Yes ☐ No

Do you feel you have unsteady balance? ☐ Yes ☐ No

PHYSCHOSOCIAL RISK FACTORS

Over the past two weeks, have you been bothered by the following problems:

Little interest/pleasure in doing things:
☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Feeling down, depressed, or hopeless:
☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Trouble falling or staying asleep, or sleeping too much:
☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Feeling tired or having little energy:
☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Poor appetite or overeating:
☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Feeling bad about yourself or that you are a failure or have let yourself or your family down:
☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television:
☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Moving or speaking so slowly that other people could have noticed:
☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

Thoughts that you would be better off dead, or of hurting yourself in some way:
☐ Not at all ☐ Several days ☐ More than half of the days ☐ Nearly every day

COMPLETE ONLY IF YOU HAVE CHECKED ANY OF PROBLEMS ABOVE

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? ☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often? ☐ Rarely ☐ Once a Week ☐ 2-3 Times a Week ☐ Daily

Have you ever smoked? ☐ Yes ☐ No

Number of years:

Have you ever used drugs? ☐ Yes ☐ No

Type of drugs: ☐ Crack/Cocaine ☐ Heroin ☐ Marijuana ☐ Other

HOME LIFE

Occupation:

Employer Name:

Who lives with you?

Marital Status: *(Please Select One)*

☐ Single ☐ Married ☐ Long-Term Relationship ☐ Other

ALLERGIES & REACTIONS

Do you have allergies? ☐ Yes ☐ No

If yes, list all known allergies:

Medications: List any medications that give you a reaction:

Medication Name:	Reaction

DIET & EXERCISE

Notes:

Do you eat fruits? ☐ Yes ☐ No — **Servings Per Day:**

Do you eat vegetables? ☐ Yes ☐ No — **Servings Per Day:**

Do you eat breads? ☐ Yes ☐ No — **Servings Per Day:**

Do you eat dairy? ☐ Yes ☐ No — **Servings Per Day:**

Do you eat meats? ☐ Yes ☐ No — **Servings Per Day:**

Do you eat sweets? ☐ Yes ☐ No — **Servings Per Day:**

Do you exercise? ☐ Yes ☐ No — **How Often & Types of Exercise:**

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HIGH STRESS

Please answer the questions below by marking the applicable column:

How often is stress a problem for you?

☐ Never/Rarely ☐ Sometimes ☐ Often ☐ Always

How well do you handle the stress in your life?

☐ I'm usually able to cope effectively ☐ At times I have problems coping ☐ I often have problems coping

GENERAL WELL-BEING

Please answer the questions below by marking the applicable column:

In general, would you say your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

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

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

In general, how satisfied are you with your life?

☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied

SLEEP

Please answer the questions below by marking the applicable column:

How many hours of sleep do you usually get each night?

_____ Hours

Do you feel fatigued?

☐ Yes ☐ No

CHRONIC PAIN

Please answer the questions below by marking the applicable column:

Have you discussed taking a daily Aspirin with your doctor?

☐ Yes ☐ No

Do you have chronic pain?

☐ Yes ☐ No

If yes, what do you currently take to help with the pain?

_____

SIGNATURES

Signature of Responsible Party: _____ **Date:** _____

Printed Name of Responsible Party: _____

Signature of Physician Reviewed: _____ **Date:** _____

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