

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

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.