MEDICARE WELLNESS - Page 1

Date:_____

Name: _____ Date of Birth: _____

Gender (Circle one): Male / Female Race:_____ Ethnicity:_____

Medical Problems:

_____
_____
_____
_____
_____
_____
_____
_____

Treating Physician/Specialist:

_____
_____
_____

Family History:

Mother: _____
Father: _____
Sibling: _____
Other: _____

Screening Questions:

Over the past two weeks, have you felt down, depressed or hopeless Yes_____ No_____
Over the past two weeks, have you felt little interest or pleasure in doing things Yes_____ No_____
How would you rate your current health:
Excellent_____Good_____Fair_____Poor_____

Functional Ability/Safety Screening Questions:

Are you able to perform your daily activities (dressing, feeding, toileting, grooming, bathing, etc.) Yes_____ No_____
Are you able to perform instrumental activities (shopping, housekeeping, cooking, using the telephone, laundry, finances, medications, transportation, etc.) Yes_____ No_____
Do you feel you need assistance performing your daily or instumental activities Yes_____ No_____

Fall Risk Questions:

Does your home have rugs in the hallway Yes_____ No_____
Do you have grab bars in the bathroom Yes_____ No_____
If you have stairs, do you have handrails inside and out Yes_____ No_____
Do you have ample lighting inside and outside your home Yes_____ No_____
Do you feel that you lose balance or get dizzy and have problems walking Yes_____ No_____

End of Life Planning Questions:

Do you have an advanced directive Yes_____ No_____
Do you have a medical power of attorney Yes_____ No_____
Do you have a living will Yes_____ No_____
If yes to any of the above, please provide copies for our records

Nutrition Questions:

Do you eat less than three meals a day Yes_____ No_____
Have you ever been treated for a drinking problem Yes_____ No_____

Cognitive Function Questions:

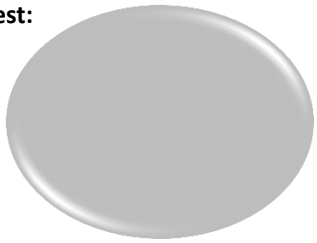
Who is the current President of the United States

_____

What day of the week is it today

_____

Clock Test:



Review Of Systems

Date: _____

Name: _____ Date of Birth: _____

General:	Yes	No
Do you worry a lot about your health?	____	____
Do you usually feel tired and worn out?	____	____
Do you feel depressed a lot of the time?	____	____
Have you recently noticed that heat or warm weather bothers you?	____	____
Have you recently been drinking more water or fluids?	____	____
Has there been any unusual weight gain or loss recently?	____	____

Skin:	Yes	No
Have you noticed:		
any change in your skin color?	____	____
any skin rashes or itching?	____	____
unusually dry skin?	____	____
any bothersome growths on your skin?	____	____
any sores or wounds that do not heal?	____	____
any change in color or size of warts?	____	____

Eyes:	Yes	No
Have you had:		
any pain in your eyes?	____	____
glaucoma?	____	____
blurry vision?	____	____
halos around lights?	____	____
change in vision?	____	____

ENT:	Yes	No
Do you have:		
any trouble hearing?	____	____
ringing or buzzing in your ears?	____	____
earaches or discharge from your ears?	____	____
a lot of nasal stuffiness?	____	____
drainage down the back of your throat?	____	____
frequent or severe nosebleeds?	____	____
persistent hoarseness?	____	____
a lump in your throat?	____	____
a sore tongue or mouth?	____	____
bleeding gums?	____	____

Respiratory:	Yes	No
Do you have:		
frequent chest colds?	____	____
a constant or bothersome cough?	____	____
coughing of blood?	____	____
sputum or phlegm between colds?	____	____
difficulty breathing?	____	____
wheezing/whistling in your chest?	____	____

Cardiovascular:	Yes	No
Do you have pain, tightness or pressure in the front or back of your chest?	____	____
If yes, is it when walking fast, working hard, or when excited?	____	____
Have you ever been told that your EKG was abnormal?	____	____
Do you have swelling in your feet or ankles?	____	____
Does your heart ever beat fast or irregularly?	____	____
Do you get cramps in your calf muscles when you walk?	____	____
Do you ever awaken at night with severe difficulty breathing?	____	____
Do your fingers or toes ever get cold, become numb, or get white or bluish?	____	____

Gastrointestinal:	Yes	No
Have you recently had any changes in your eating habits?	____	____
Are there any special foods that cause you to be upset or have stomach pains, nausea, etc?	____	____
Do you tend to burp a lot?	____	____
Have you recently noted any trouble swallowing?	____	____
Do you have a lot of indigestion or heartburn?	____	____
Have you ever vomited blood?	____	____
Are you bothered with constipation?	____	____
Do you have frequent loose stools or diarrhea?	____	____
Do you pass a lot of gas?	____	____
Do you have a poor appetite?	____	____
Do you ever awake at night with the feeling of fullness under your breast bone?	____	____
Have you ever passed blood from your rectum?	____	____
Have you ever had black or tarry stool?	____	____
Have you noticed any recent changes in your bowel movements?	____	____
Do you take laxatives regularly?	____	____
Do you have frequent nausea and/or vomiting?	____	____

Genitourinary:	Yes	No
Do you have:		
anything wrong with your genitals (privates)?	____	____
burning or pain when urinating?	____	____
to pass water frequently?	____	____
to pass more water than you used to?	____	____
trouble passing water?	____	____
to get up at night to urinate?	____	____
trouble with losing urine when you cough or sneeze?	____	____
a problem dripping urine?	____	____
Have you ever passed blood in your urine?	____	____
Have you had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation)	____	____
MEN - Do you have prostate gland trouble?	____	____

Review Of Systems

Date: _____

Name: _____ Date of Birth: _____

Musculoskeletal:	Yes	No
Do you have a problem with back pain?	_____	_____
Do you have pain in your legs or feet?	_____	_____
Does back pain interfere with your work or activities?	_____	_____
Do you have joint pain or stiffness?	_____	_____
Do you have trouble walking or using your hip or knee joints?	_____	_____

Central Nervous System:	Yes	No
Do you have frequent or severe headaches?	_____	_____
Do you often have spells of dizziness, faintness or lightheadedness?	_____	_____
Have you seen double?	_____	_____
Do you sometimes lose track of what happens around you for a short time?	_____	_____
Do you sometimes lose the ability to speak for a few seconds?	_____	_____
Have you recently fainted, blacked out or lost consciousness?	_____	_____
Do you have trouble remembering recent events?	_____	_____
Have you ever had convulsions or fits?	_____	_____
Do you have numbness or tingling in your head, arms or legs?	_____	_____
Do you consider yourself a nervous person?	_____	_____
Do you cry a lot for no reason?	_____	_____
Have you ever had an urge to commit suicide?	_____	_____
Do you ever hear voices or see people when no one is around?	_____	_____
Do you ever have a feeling that someone is trying to harm you?	_____	_____

Personal Habits:	Yes	No
Do you regularly smoke:		
Cigarettes:	_____	_____
How many per day?_____		
For how many years?_____		
Pipe, Cigars or use Chewing Tobacco:	_____	_____
For how many years?_____		
Are you a former smoker/tobacco user?	_____	_____
If so, how long ago did you quit?_____		
Do you drink:		
Hard Liquor:	_____	_____
1-3 oz per day_____over 3 oz per day_____		
Beer:	_____	_____
1 bottle a day_____2 bottles_____3 or more_____		
Wine:	_____	_____
1 glass a day_____2 glasses_____3 or more_____		
Do you drink coffee?	_____	_____
Do you drink 3 or more cups a day?	_____	_____
Do you have difficulty sleeping?	_____	_____
If yes, how often?_____		
Do you awaken very early in the morning without an apparent cause and find it difficult to go back to sleep?	_____	_____
If yes, how often?_____		
Do you exercise?	_____	_____
# of days a week_____Minutes a day_____		
If you exercise, how intense is your exercise?		
Light____Moderate____Heavy____Very Heavy____		
Do you wear a seat belt when traveling in a car?	_____	_____
Are you sexually active?	_____	_____
Have you had more than one partner in the past 2 years?	_____	_____
Do you protect against STD's?	_____	_____
Do you use contraception/birth control?	_____	_____

Women Only	Yes	No
Did your menstrual cycle start before you were 10?	_____	_____
Did your menstrual cycle start after your were 15?	_____	_____
Are your menstrual cycles irregular?	_____	_____
Are your periods less frequent than every 4 weeks?	_____	_____
Are your periods more frequent than every 4 weeks?	_____	_____
Do you use more than 10 pads or have to use a super size pad or tampon for your periods?	_____	_____
Do you pass clots with your periods?	_____	_____
Do you become bloated or gain weight just before your periods?	_____	_____
Have you passed the menopause or change?	_____	_____
Do you have hot flashes?	_____	_____
Have you had an abortion or miscarriage?	_____	_____
Have you had lumps in your breast?	_____	_____
Have you had any discharge from your nipples?	_____	_____
Have you used an intrauterine device (IUD)?	_____	_____
Have you used other birth control measures?	_____	_____

GMS Florida West Coast, Inc.

A Physician Group Practice

Preventive/Physical

We applaud your efforts to maintain your health by utilizing your preventive care physical benefits. In today's age of medicine and government involvement, these benefits continue to change, unfortunately covering less and less under preventive care. Your exact benefits are not only determined by what insurance company you have but also what plan you have chosen through your company's individual offerings. Your company may offer multiple different plan choices, each having different preventive care benefits. This makes it impossible for our office to accurately know your benefits.

Medically we feel that an EKG and certain lab tests (CBC, CMP, Lipid Panel, and TSH) are appropriate and have been previously covered under preventive care. However, you are welcome to check your individual benefit package through your employer or insurance company to see what your plan specifically covers under your current preventive care benefits.

Please realize that all insurance companies and Medicare agree that preventive care does not include any procedures or treatments including the writing of prescriptions. Further, many insurances will not cover specialty lab tests such as Testosterone, Vitamin D or hormone levels under preventive care either. We are providing you this information so that you are aware of preventive care coverage issues which currently exist and of your possible financial responsibilities. Please sign below acknowledging that these issues have been brought to your attention.

We thank you for allowing our office to provide your health care and hope to do so in the future.

_____ _____

Patient Signature Date