Sample AWV patient intake form

Colorado M.E.S.A. Initiative
Medicare Experts/Senior Access
Innovations in Geriatric Practice and Alzheimer's Care

DEMOGRAPHIC INFORMATION

PATIENT DEMOGRAPHIC INFORMATION *(This section refers to the PATIENT ONLY)*

First Name: _____ Middle: _____ Last: _____

Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. ☐ Other: _____

Suffix: ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ MD ☐ DDS ☐ Other: _____

Nickname/Preferred Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Home Fax: _____

Date of Birth: ___/___/___ SSN: ___-___-___ Sex: (*Circle One*) Male Female

Email: _____

Marital Status: (*Circle One*)

Single Married Divorced Widowed Legally Separated Unknown

Spouse Name: *(If Applicable)* _____

Race: (*Circle One*)

Caucasian	Black	Hispanic	Asian
Native American	Pacific Islander	Native Hawaiian	Asian Pacific American
Black Non-Hispanic	White Non-Hispanic	American Indian	Alaskan Native
Subcontinent Asian American	Other Race or Ethnicity		

Primary Language: *(Circle One)*

Arabic	English	French	German	Spanish	Korean
Chinese	Japanese	Russian	Armenian	Vietnamese	Tagalog
Hindustani	Hmong	Laotian	Portuguese	Cambodian	Punjabi
Sign Language	Other: _____				

Employment Status: (*Circle One*) Employed Self-employed Unemployed Disabled Retired Part-time student Full-time student

Employer Name: _____ Work Phone: _____

Previous Physician Information:

Please name your previous Primary Care Physician (PCP): _____

Do you plan to continue being followed by this physician? ☐ No ☐ Yes

Demographic Information (9/11) D2

First Name: _____ Middle: _____ Last: _____

How did you hear about Senior Care of Colorado/IPC: *(Circle All Applicable)*

Family Member	Spouse	Friend	Senior Care Website
Internet Search	Walk In	Direct Mailing/Postcard	Exhibit Booth/Table
Covenant Village of CO	Seniors' Resource Center	Holly Creek (CLC)	Clermont Park (CLC)

Ad/Article/Publication (*Please circle below*):

Yellow Pages Prime Time for Seniors Seniors Blue Book 5280 Magazine Other

Assisted Living Faciliy: _____ Local Area Hospital: _____

Nursing Home/SNF: _____ Home Care Agency: _____

DME/Oxygen Vendor: _____ Hospice Agency: _____

Insurance Plan/Directory: _____ Local Senior Center: _____

Other Provider/Specialist: _____ Other: _____

INSURANCE INFORMATION

Please complete thoroughly. We will need a copy of your insurance cards.

Name of Policy Holder: _____

Relationship to patient? ☐ Self ☐ Husband ☐ Wife ☐ Parent ☐ Other: _____

Name of **Primary** Insurance: _____

Member ID/Policy #: _____ Group #: _____

Name of **Secondary** Insurance: _____

Member ID/Policy #: _____ Group #: _____

ONLY *complete this section if the Policy Holder is* ***NOT*** *the Patient.*

First Name: _____ Middle: _____ Last: _____

Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. ☐ Other: _____

Suffix: ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ MD ☐ DDS ☐ Other: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Pager: _____

Date of Birth: / / SSN: - - Sex: (*Circle One*) Male Female

Email: _____

Employment Status: (*Circle One*) Employed Self-employed Unemployed Disabled Retired Part-time student Full-time student

Employer Name: _____

First Name: _____ Middle: _____ Last: _____

RESPONSIBLE PARTY/GUARANTOR INFORMATION

This is the person who should receive invoices, statements and financial correspondence. ***ONLY*** *complete this section if the Responsible Party/Guarantor is* ***NOT*** *the Patient or the Policy Holder.*

☐ Self (*Skip to Emergency Contact Section*) ☐ Policy Holder (*Skip to Emergency Contact Section*)

First Name: _____ Middle: _____ Last: _____

Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. ☐ Other: _____

Suffix: ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ MD ☐ DDS ☐ Other: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Pager: _____

EMERGENCY CONTACT INFORMATION *(This section refers to the EMERGENCY CONTACT ONLY)*

☐ Policy Holder (*Skip to Guardian Section*) ☐ Responsible Party/Guarantor (*Skip to Guardian Section*)

Patient's Relationship to Contact: *(Circle One)*

Wife Husband Child Grandchild Parent Niece/Nephew Aunt Uncle
Employee Grandparent Other: _____

Emergency contact is Guardian? ☐ Yes ☐ No

First Name: _____ Middle: _____ Last: _____

Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. ☐ Other: _____

Suffix: ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ MD ☐ DDS ☐ Other: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Pager: _____

Sex: (*Circle One*) Male Female SSN: ___ - ___ - ___

Primary Language: *(Circle One)*

Arabic	English	French	German	Spanish	Korean
Chinese	Japanese	Russian	Armenian	Vietnamese	Tagalog
Hindustani	Hmong	Laotian	Portuguese	Cambodian	Punjabi
Sign Language	Other: _____				

First Name: _____ Middle: _____ Last: _____

GUARDIAN INFORMATION *(This section refers to the GUARDIAN ONLY)*

Relationship to patient? ☐ Self ☐ Husband ☐ Wife ☐ Parent ☐ Other: _____

ONLY *complete this section if the Guardian is* ***NOT*** *the Insurance Policy Holder, the Responsible Party/Guarantor or the Emergency Contact.*

Patient's Relationship to Guardian: *(Circle One)*

Wife Husband Child Grandchild Parent Niece/Nephew Aunt Uncle
Employee Grandparent Other: _____

Clinical correspondence will be mailed to the guardian at the patient's address.

First Name: _____ Middle: _____ Last: _____

Prefix: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. ☐ Other: _____

Suffix: ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ MD ☐ DDS ☐ Other: _____

Sex: (*Circle One*) Male Female SSN: ___ - ___ - ___

Primary Language: *(Circle One)*

Arabic	English	French	German	Spanish	Korean
Chinese	Japanese	Russian	Armenian	Vietnamese	Tagalog
Hindustani	Hmong	Laotian	Portuguese	Cambodian	Punjabi
Sign Language	Other: _____				

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Pager: _____

PLEASE SIGN BY BOTH X's

I authorize payment of medical benefits to Physician or supplier of these services and all future claims.

X _____
Signed (Insured or Authorized Person)

I authorize the release of any medical information necessary to process this claim and all future claims.

X _____
Signed (Insured or Authorized Person)

PREFERRED PHARMACY

Pharmacy Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

First Name: _____ Middle: _____ Last: _____

COMPREHENSIVE QUESTIONNAIRE

Since this is your medical history and it will be used in evaluating your health, it is extremely important that the questions be answered as accurately and completely as possible. All information provided is kept confidential.

MEDICATIONS

1. List all medicines that you use. (Prescriptions, Non-Prescriptions/Over-the-Counter, Natural Products)

Name of Current Medications Used Regularly	What Strength/Dose?	How do you use it? (How many? How many times a day?)
Example: Tylenol	500 mg	1 pill 3 times a day by mouth

2. Do you have any medication allergies/adverse reactions?

☐ No ☐ Yes If Yes, please specify below: →

NAME OF MEDICATION	REACTION

3. Do you take a daily aspirin? ☐ Yes ☐ No

First Name: _____ Middle: _____ Last: _____

SURGERIES

1. List Surgeries (Operations) Use separate page, if needed.

DATE	SURGERY (OPERATIONS)

HOSPITALIZATIONS

1. List Other Hospitalizations (Last 3 years) Use separate page, if needed.

DATE	REASON

First Name: _____ Middle: _____ Last: _____

IMMUNIZATIONS

A. When was your last **tetanus** shot? ___/___/___

B. When was your last **influenza** vaccination? ___/___/___

C. Do you get an **annual** influenza vaccination? ☐ Yes ☐ No

D. Have you had a **pneumonia** vaccination (Pneumovax)? ☐ Yes ___/___/___ ☐ No

E. Have you had a **shingles** vaccination (Zostavax)? ☐ Yes ___/___/___ ☐ No

F. Have you had a **tuberculosis skin test** (PPD or Tine)? ☐ Yes ☐ No

If yes, was it negative? ☐ Yes ☐ No Date of test? ___/___/___

DIAGNOSTIC STUDIES & SCREENINGS

1. Please check all of the diagnostic studies and/or screenings you have had performed and enter a four digit year.

TEST	YEAR	COMMENTS
☐ EKG or ECG (Electrocardiogram)		
☐ Treadmill or Exercise Stress Test		
☐ Chest X-Ray		

Please include the year and month for below:

	YEAR	MONTH	COMMENTS
☐ Cholesterol			
☐ Thyroid			
☐ Fecal Occult Blood			
☐ Sigmoidoscopy or Colonoscopy			
☐ Prostate Cancer			
☐ Sonogram (AAA)			
☐ HIV			
☐ Hepatitis B			
☐ Glaucoma			
☐ Bone Densitometry			
☐ Mammogram			
☐ Pelvic Exam/Pap Smear			

HEARING SCREENING

1. Have you noticed any hearing difficulties? ☐ Yes ☐ No

2. Have you had a hearing evaluation? ☐ Yes ☐ No

DEPRESSION SCREENING

1. Over the past two weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ No

2. Over the past two weeks, have you felt little interest or pleasure in doing things? ☐ Yes ☐ No

First Name: _____ Middle: _____ Last: _____

PAST MEDICAL HISTORY

1. Which medical conditions do you have or have you had in the past? (*Check all that apply*)

A. Eye & Ear Problems

- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Glaucoma
- ☐ Hearing loss/Hearing aid
- ☐ Other, please specify: _____

Name of Specialist(s) Seen: _____

B. Heart Problems

- ☐ Heart attack Year _____
- ☐ High blood pressure
- ☐ Heart failure
- ☐ Irregular heart beats (Arrhythmias)
- ☐ Other, please specify: _____

Name of Specialist(s) Seen: _____

C. Lung Problems

- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Other, please specify: _____

Name of Specialist(s) Seen: _____

D. Bone & Joint Problems

- ☐ Arthritis
- ☐ Fractured hip, wrist or spine (*Circle which one*)
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other, please specify: _____

Name of Specialist(s) Seen: _____

E. Gland Problems

- ☐ Diabetes
- ☐ Thyroid underactive (low)
- ☐ Thyroid overactive (high)
- ☐ Other, please specify: _____

Name of Specialist(s) Seen: _____

F. Kidney & Urinary Tract Problems

- ☐ Kidney disease
- ☐ Frequent bladder or kidney infections
- ☐ Prostate disease
- ☐ Urinary incontinence
- ☐ Other, please specify: _____

Name of Specialist(s) Seen: _____

First Name: _____ Middle: _____ Last: _____

G. Gastrointestinal Problems

- ☐ Ulcers
- ☐ Heartburn/Hiatal hernia
- ☐ Diverticulosis
- ☐ Liver disease/Cirrhosis
- ☐ Hepatitis
- ☐ Polyps
- ☐ Gallbladder disease
- ☐ Other, please specify: _____

Name of Specialist(s) Seen: _____

H. Nervous System Problems

- ☐ Stroke
- ☐ Dementia or Alzheimer's disease
- ☐ Other, please specify: _____
- ☐ Parkinson's disease
- ☐ Epilepsy or seizures

Name of Specialist(s) Seen: _____

I. Other Health Problems

- ☐ Anemia
- ☐ Hernia
- ☐ Thrombosis (blood clots)
- ☐ Depression
- ☐ Allergies, please specify: _____
- ☐ Cancer, of what: _____
- ☐ Sexual function problems, please specify: _____
- ☐ Other, please specify: _____

Name of Specialist(s) Seen: _____

First Name: _____ Middle: _____ Last: _____

FUNCTIONAL ABILITY

ACTIVITIES OF DAILY LIVING

1. We want to know if you need help with any of the following tasks and who helps you.

Task	Don't Need Help	Need Help	If you need help, who helps? (Name and Relationship)
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing			
Using the telephone			
Taking your medicines			
Preparing meals			
Managing money/ Financial affairs/ Checkbook			
Doing laundry			
Doing house work			
Shopping for groceries			
Driving			
Doing "handyman" work			
Climbing a flight of stairs			
Getting to places beyond walking distance			

SAFETY SCREENING

1. Have you had a fall in your home within the last year?

☐ Yes ☐ No

If yes, was the fall caused by:

☐ Loose throw rug
☐ Lack of grab bar in the bathroom
☐ Lack of handrail on the stairs
☐ Poor lighting

First Name: _____ Middle: _____ Last: _____

SOCIAL HISTORY

1. With whom do you live? (Check One)

- ☐ Alone
- ☐ Spouse or partner
- ☐ Child or other family member
- ☐ Other(s), not family
- ☐ Other, please specify: _____

2. Which of the following best describes your residence? (Check One)

- ☐ Single-family house
- ☐ Condo or apartment
- ☐ Retirement hotel
- ☐ Other, please specify: _____
- ☐ Live with other(s) in their home, condo or apartment
- ☐ Board and care/Residential care facility
- ☐ Nursing Home

3. Are you currently (Check One)

- ☐ Married
- ☐ Single/Never married
- ☐ Divorced/Separated
- ☐ Living with Significant other
- ☐ Widowed

4. How many children do you have? _____

Are you in regular contact with your children? ☐ Yes ☐ No

5. How much school did you complete? (Check One)

- ☐ Less than 6th grade
- ☐ Less than high school graduate
- ☐ High school graduate
- ☐ Some college
- ☐ College graduate
- ☐ More than college graduate

6. What has been your principal occupation? _____

7. Do you employ someone to provide care or help you in your home? ☐ Yes ☐ No

If yes, approximately how many hours a day and how many days a week is your paid helper available to you? _____ hours a day _____ days a week

Is this sufficient to meet your needs? ☐ Yes ☐ No

First Name: _____ Middle: _____ Last: _____

8. Do you get help from a family member or friend in your home? ☐ Yes ☐ No

If yes, approximately how many hours a day and how many days a week is your family member or friend available to you? _____ hours a day _____ days a week

Is this sufficient to meet your needs? ☐ Yes ☐ No

9. Who would you call if you were sick and needed help? _____

10. Do you provide care for a family member? ☐ Yes ☐ No

11. Do you drink caffeine, including coffee, tea or soda?

☐ Daily ☐ Occaisionally ☐ Never

12. Do you drink alcohol, including beer and wine, or other alcohol (such as vodka, whiskey, gin)?

☐ Daily
☐ Almost daily (4 to 6 times a week)
☐ 1 to 3 times a week
☐ Less than 1 time a week
☐ Never

13. If you drink alcohol, has anyone ever been concerned about your drinking?

☐ Yes ☐ No

14. Have you ever smoked cigarettes? ☐ Yes ☐ No

If yes, are you smoking now? ☐ Yes ☐ No

If no,

How many years ago did you quit? _____

How many years did you smoke? _____

How much did you smoke? _____ packs per day

If yes,

How many years have you smoked? _____

How much do you smoke? _____ packs per day

15. Have you ever used illegal or illicit drugs? ☐ Yes ☐ No

First Name: _____ Middle: _____ Last: _____

FAMILY HISTORY

1. Age at death

Father	Mother	Brother	Sister

2. Do any members of your family have/had any of the following conditions? (Check all that apply.)

CONDITION	Father	Mother	Brother	Sister	Child
☐ Dementia or Alzheimer's disease	☐	☐	☐	☐	☐
☐ Cancer, of what?	☐	☐	☐	☐	☐
☐ Heart disease	☐	☐	☐	☐	☐
☐ Kidney disease	☐	☐	☐	☐	☐
☐ Liver disease	☐	☐	☐	☐	☐
☐ Hypertension	☐	☐	☐	☐	☐
☐ Stroke	☐	☐	☐	☐	☐
☐ Diabetes	☐	☐	☐	☐	☐
☐ Depression	☐	☐	☐	☐	☐
☐ Other: _____	☐	☐	☐	☐	☐

3. Did anyone in your family die at a young age? (< 60) _____

PLANNING FOR FUTURE HEALTH CARE

1. Do you have a medical Durable Power of Attorney?

☐ Yes (If yes, please bring a copy) ☐ No

2. Do you have a living will?

☐ Yes (If yes, please bring a copy) ☐ No

3. Would you like us to provide you with:

☐ 5 Wishes ☐ Colorado MOST Form

4. Are there any religious or social issues we need to be aware of in advising you about your advanced directives? (Blood transfusions/Feeding tubes)

☐ Yes ☐ No

If yes, please explain: _____

First Name: _____ Middle: _____ Last: _____

REVIEW OF SYSTEMS

Please indicate whether you have ever had a significant problem with any of the symptoms or conditions listed below.

GENERAL	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
1. Unexplained weight loss	☐	☐	☐	_____	Yes No	
What was the magnitude of this weight loss?	☐ 0 - 5 lbs.	☐ 5 - 15 lbs.	☐ 15 - 25 lbs.	☐ >25 lbs.		
2. Unexplained weight gain	☐	☐	☐	_____	Yes No	
What was the magnitude of this weight gain?	☐ 0 - 5 lbs.	☐ 5 - 15 lbs.	☐ 15 - 25 lbs.	☐ >25 lbs.		
3. Chronic fatigue	☐	☐	☐	_____	Yes No	
4. Change in appetite	☐	☐	☐	_____	Yes No	
5. Night sweats	☐	☐	☐	_____	Yes No	
6. Fever or chills	☐	☐	☐	_____	Yes No	
7. Any type of cancer	☐	☐	☐	_____	Yes No	

HEART/VASCULAR	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
8. Chest pain or pressure	☐	☐	☐	_____	Yes No	
9. Chest pain with exertion	☐	☐	☐	_____	Yes No	
10. Heart attack	☐	☐	☐	_____	Yes No	
11. Rapid/Irregular heartbeats	☐	☐	☐	_____	Yes No	
12. Fainting/Lightheadedness	☐	☐	☐	_____	Yes No	
13. High blood pressure	☐	☐	☐	_____	Yes No	
14. Rheumatic fever	☐	☐	☐	_____	Yes No	
15. Calf pain with exercise	☐	☐	☐	_____	Yes No	
16. Varicose veins	☐	☐	☐	_____	Yes No	
17. Phlebitis	☐	☐	☐	_____	Yes No	
18. Stroke	☐	☐	☐	_____	Yes No	
19. High blood cholesterol	☐	☐	☐	_____	Yes No	
20. High blood triglycerides	☐	☐	☐	_____	Yes No	

SLEEP	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
21. Trouble falling asleep	☐	☐	☐	_____	Yes No	
22. Trouble staying asleep	☐	☐	☐	_____	Yes No	

Review of Systems (9/11) **ROS2**

First Name: _____ Middle: _____ Last: _____

BONE AND JOINT	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
23. Chronic joint and muscle pain	☐	☐	☐	_____	Yes No	
24. Low back pain	☐	☐	☐	_____	Yes No	
25. Swollen/stiff joints	☐	☐	☐	_____	Yes No	
26. Arthritis	☐	☐	☐	_____	Yes No	
27. Gout	☐	☐	☐	_____	Yes No	

EYES	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
28. Decrease in vision	☐	☐	☐	_____	Yes No	
Date of last eye exam?	/ /					
29. Double vision	☐	☐	☐	_____	Yes No	
30. Glaucoma	☐	☐	☐	_____	Yes No	
31. Color blindness	☐	☐	☐	_____	Yes No	
32. Cataracts	☐	☐	☐	_____	Yes No	
33. Serious injury to eye	☐	☐	☐	_____	Yes No	

GASTROINTESTINAL	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
34. Fatty food intolerance	☐	☐	☐	_____	Yes No	
35. Ulcer disease	☐	☐	☐	_____	Yes No	
36. Frequent heartburn	☐	☐	☐	_____	Yes No	
37. Vomited blood	☐	☐	☐	_____	Yes No	
38. Gallbladder trouble	☐	☐	☐	_____	Yes No	
39. Abdominal pain	☐	☐	☐	_____	Yes No	
40. Jaundice, hepatitis, or cirrhosis	☐	☐	☐	_____	Yes No	
41. Frequent diarrhea	☐	☐	☐	_____	Yes No	
42. Diarrhea caused by milk/ lactose intolerance	☐	☐	☐	_____	Yes No	
43. Blood in stools	☐	☐	☐	_____	Yes No	
44. Black stool	☐	☐	☐	_____	Yes No	
45. Hemorrhoids	☐	☐	☐	_____	Yes No	
46. Colon polyps	☐	☐	☐	_____	Yes No	
47. Chronic constipation	☐	☐	☐	_____	Yes No	

First Name: _____ Middle: _____ Last: _____

EAR-NOSE-THROAT	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
48. Hearing loss	☐	☐	☐	_____	Yes No	
49. Prolonged exposure to loud noise	☐	☐	☐	_____	Yes No	
50. Ringing in ears	☐	☐	☐	_____	Yes No	
51. Chronic ear infections	☐	☐	☐	_____	Yes No	
52. Ruptured eardrum	☐	☐	☐	_____	Yes No	
53. Snoring	☐	☐	☐	_____	Yes No	
54. Sinus infection	☐	☐	☐	_____	Yes No	
55. Allergy related nasal congestion	☐	☐	☐	_____	Yes No	

ENDOCRINE	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
56. Thyroid disease	☐	☐	☐	_____	Yes No	
57. High blood sugar	☐	☐	☐	_____	Yes No	
58. Diabetes	☐	☐	☐	_____	Yes No	

PULMONARY	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
59. Chronic cough or phlegm	☐	☐	☐	_____	Yes No	
60. Wheezing	☐	☐	☐	_____	Yes No	
61. Asthma	☐	☐	☐	_____	Yes No	
62. Tuberculosis	☐	☐	☐	_____	Yes No	
63. Bronchitis	☐	☐	☐	_____	Yes No	
64. Pneumonia	☐	☐	☐	_____	Yes No	
65. Emphysema	☐	☐	☐	_____	Yes No	
66. Coughed up blood	☐	☐	☐	_____	Yes No	
67. Shortness of breath	☐	☐	☐	_____		

First Name: _____ Middle: _____ Last: _____

HEMATOLOGY	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
68. Anemia	☐	☐	☐	_____	Yes No	
69. Bleeding disorder	☐	☐	☐	_____	Yes No	
70. Previous blood transfusion	☐	☐	☐	_____	Yes No	
71. Enlarged or swollen lymph nodes	☐	☐	☐	_____	Yes No	

NEUROPSYCHIATRY	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
72. Loss of consciousness	☐	☐	☐	_____	Yes No	
73. Vertigo	☐	☐	☐	_____	Yes No	
74. Memory problems	☐	☐	☐	_____	Yes No	
75. Seizures or epilepsy	☐	☐	☐	_____	Yes No	
76. Frequent headaches	☐	☐	☐	_____	Yes No	
77. Numbness or tingling of arms, legs, or face	☐	☐	☐	_____	Yes No	
78. Difficulty sleeping	☐	☐	☐	_____	Yes No	
79. Depression	☐	☐	☐	_____	Yes No	
80. Anxiety	☐	☐	☐	_____	Yes No	
81. Thoughts of suicide	☐	☐	☐	_____	Yes No	
82. Nervous breakdown	☐	☐	☐	_____	Yes No	
83. Psychiatric or psychological counseling	☐	☐	☐	_____	Yes No	

DERMATOLOGY	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
84. Skin rash	☐	☐	☐	_____	Yes No	
85. Skin cancer	☐	☐	☐	_____	Yes No	
86. Shingles/herpes zoster	☐	☐	☐	_____	Yes No	
87. Skin sores that won't heal	☐	☐	☐	_____	Yes No	
88. Unusual moles	☐	☐	☐	_____	Yes No	
89. Mouth sores that won't heal	☐	☐	☐	_____	Yes No	
90. Skin or toenail fungus	☐	☐	☐	_____	Yes No	
91. Psoriasis	☐	☐	☐	_____	Yes No	
92. Other	☐	☐	☐	_____	Yes No	

First Name: _____ Middle: _____ Last: _____

GENITOURINARY	YES	NO	DON'T KNOW	IF YES, YEAR OF ONSET?	STILL A PROBLEM? (Circle One)	COMMENTS
93. Sexually transmitted disease	☐	☐	☐	_____	Yes No	
Syphilis	☐	☐	☐	_____	Yes No	
Gonorrhea	☐	☐	☐	_____	Yes No	
Herpes	☐	☐	☐	_____	Yes No	
94. HIV positive/AIDS	☐	☐	☐	_____	Yes No	
95. Blood in urine	☐	☐	☐	_____	Yes No	
96. Burning or pain during urination	☐	☐	☐	_____	Yes No	
97. Kidney/bladder infection	☐	☐	☐	_____	Yes No	
98. Kidney stones	☐	☐	☐	_____	Yes No	
Questions 99 - 102: Male specific						
99. Impotence/Erectile dysfunction	☐	☐	☐	_____	Yes No	
100. Difficulty urinating starting or stopping	☐	☐	☐	_____	Yes No	
101. Awakening to urinate	☐	☐	☐	_____	Yes No	
102. Prostate trouble	☐	☐	☐	_____	Yes No	
Question 103: Female specific						
103. Sexual problems (i.e., pain with intercourse)	☐	☐	☐	_____	Yes No	

If yes, please comment: _____

_____

_____

_____

_____

OTHER

104. Any other primary concern(s)/concern(s) you would like to cover today?

_____

_____

_____

_____

_____

_____

_____

First Name: _____ Middle: _____ Last: _____

PREVENTIVE SCREENING & COUNSELING FORM

PHYSICAL EXAM

Ht _____ Wt _____ BMI _____ BP _____

COUNSELING

Based on history, exam and screening (including risks, interventions underway or planned, and benefits)

- ☐ Smoking cessation
- ☐ Diet
- ☐ Exercise
- ☐ Pain Management
- ☐ Medication compliance
- ☐ Safety
- ☐ Family support/Grief/Bereavement
- ☐ Community resources
- ☐ Nutritional supplements
- ☐ Cognitive screening

REFERRALS

- ☐ Social services
- ☐ Nutritional services
- ☐ Sub specialist
- ☐ Diagnostics
- ☐ Rehab ☐ PT ☐ OT ☐ ST
- ☐ Home care

PREVENTIVE SCREENINGS/IMMUNIZATIONS

- ☐ Mammogram
- ☐ PSA
- ☐ Colonoscopy
- ☐ BMD
- ☐ Sonogram (AAA)
- ☐ Cardiovascular screening blood tests
- ☐ Diabetes screening tests
- ☐ Flu vaccine
- ☐ Pneumo vaccine

PREVENTIVE VACCINES (*May not be covered under Medicare Part B*)

- ☐ Varicella
- ☐ Zoster
- ☐ Tdap
- ☐ Td
- ☐ MMR
- ☐ Meningococcal vaccine
- ☐ Hepatitis A vaccine
- ☐ Hepatitis B vaccine

PATIENT EDUCATION HANDOUTS REVIEWED AND DISCUSSED WITH PATIENT

- ☐ Branded Pharmacology
- ☐ Cardiovascular
- ☐ Dementia
- ☐ Dermatology
- ☐ Ear, Nose and Throat
- ☐ Endocrinology
- ☐ Gastrointestinal
- ☐ Gynecological/Urology
- ☐ Infectious Disease
- ☐ Neurology
- ☐ Opthalmology
- ☐ Orthopaedic
- ☐ Psychology
- ☐ Pulmonary
- ☐ Renal
- ☐ Rheumatology
- ☐ Miscellaneous, specify below:

_____

DEPRESSION SCREENING

- ☐ Positive
- ☐ Negative

COGNITIVE SCREENING

- ☐ 3 Word Recall
- ☐ Clock Draw

RETURN VISIT DATE

_____ / _____ / _____

_____ _____

Provider Signature Date