St. Luke Community Healthcare
Medicare Annual Wellness Visit

Patient label here

Patient's name: _____ D.O. B._____/_____/_____ Exam Date: _____

Allergies: _____ Primary Care Provider_____

Medications, supplements, vitamins name:	Route (i.e., oral, topical, etc.)	Dose	Frequency (e.g., 1 – 2 times/day)

** Add additional page if further space for medications is needed**

In general, how would you rate your health?
excellent | very good | good | fair | poor

How often do you get social/emotional support?
all the time | more than half the time | half the time| less than half the time | rarely | not at all

Behavior Screen
1. How often do you take your medications as directed?
   always | sometimes | seldom | I do not take any medications
2. How often do you use your seat belt?
   All the time | some of the time | rarely or not at all

Function Screen
1. Please circle any activities that you need help with:
   eating | toileting | bathing | dressing | moving in and out of the bed or a chair
   using the phone | transportation | shopping | preparing meals | housework | laundry |
   managing or taking medications | managing finances | no assistance needed
2. Do you have trouble controlling your bladder? ☐ YES ☐ NO

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Hearing Loss Screen

1. Please circle anything that applies to how your hearing affects your life:
   No problems with hearing | embarrasses you when meeting new people | frustrates you when talking with family | have difficulty hearing when someone whispers | feel impaired by a hearing problem | hearing causes difficulty when visiting people | attend religious services less often because of hearing | argue with family because of hearing | difficulty hearing radio or TV | hearing limits or hampers personal or social life | difficulty hearing in a restaurant

Home safety screen

1. Please circle all that applies to you and your home:
   Entry ways are well lit | Sidewalks and entryways maintained | Carbon monoxide detector installed | Smoke detectors are installed | Unidentified or expired medications are thrown out

Fall Screen

1. Have you had a fall in the last year? ☐ YES ☐ NO
2. Do you feel unsteady when standing or walking? ☐ YES ☐ NO
3. Do you worry about falling? ☐ YES ☐ NO

Past personal illnesses, injuries, operations or diagnoses:	Date	Hospitalized?

Family Health History: particularly your parents and siblings (check those that apply)

☐ Alcoholism □ Mother □ Father □ Sister □ Brother	☐ Liver Disease □ Mother □ Father □ Sister □ Brother	☐ High Cholesterol □ Mother □ Father □ Sister □ Brother	☐ Obesity □ Mother □ Father □ Sister □ Brother
☐ Arthritis □ Mother □ Father □ Sister □ Brother	☐ Diabetes □ Mother □ Father □ Sister □ Brother	☐ High Blood Pressure □ Mother □ Father □ Sister □ Brother	☐ Stroke □ Mother □ Father □ Sister □ Brother
☐ Cancer □ Mother □ Father □ Sister □ Brother	☐ Heart Disease □ Mother □ Father □ Sister □ Brother	☐ Kidney Disease □ Mother □ Father □ Sister □ Brother	☐ Thyroid Disease □ Mother □ Father □ Sister □ Brother

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Additional History/Notes:

What is your occupation? _____

Who do you live with? _____

Days per week that you eat a well-balanced diet: _____

What is your caffeine intake per day? _____

Number of high-fat foods you have per day: _____

Number of servings of fruits and vegetables you have per day: _____

Servings of milk/calcium that you have per day: _____

How often you eat out per week: _____

How often you read food labels: _____

Your weight over the past year: Stable | Decreased >10lbs | Increased >10lbs | Other _____

How many times/week do you exercise? _____ Duration? _____ Type? _____

Tobacco Use: YES ☐ NO ☐ If yes, (smoke or chew) how many packs per day? _____
Alcohol Use: YES ☐ NO ☐ If yes, how many drinks per day? _____
Drug Use: YES ☐ NO ☐ If yes, describe _____

Current list of patient's providers/specialists/medical equipment suppliers:

NAME	SPECIALTY	REASON

Advanced care planning

1. Patient Consent: "I consent to discuss end-of-life issues with my healthcare provider."

_____ _____
Patient/Guardian Signature Date