Save Reset

Gwinnett Clinic
Medicare Wellness Visit

Dr/NP _____
Location _____

Patient Name: _____ DOB: _____/_____/_____ Age: _____

Allergies to Meds: _____

Medical History

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

Tobacco use: YES ☐ NO ☐ *If yes,* smoke or chew (circle one)? How many packs per day? ___
Alcohol use: YES ☐ NO ☐ *If yes,* how many drinks per day? _____
Drug use: YES ☐ NO ☐ *If yes*, describe _____

Women only: Have you ever been pregnant? YES / NO *If yes,* how many pregnancies? _____

How many servings of fruits and vegetables do you have per day? _____

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

How many children do you have? _____ Who do you live with? _____

What is your occupation? _____

Current Medication List

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

Please attach an additional page if further space is needed for medications.

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Patient Name: _____ DOB: _____/_____/_____ Age: _____

Current Providers/Doctors and Suppliers

Name	Specialty	Reason

Family History

(particularly parents, grandparents, siblings)

☐ Alcoholism	☐ Cancer	☐ High Cholesterol	☐ Obesity
☐ Arthritis	☐ Diabetes	☐ Hypertension	☐ Stroke
☐ Cancer	☐ Heart Disease	☐ Liver or Kidney Disease	☐ Thyroid Disease

Hearing Loss Screen

1. Do you have trouble hearing the TV or radio when others don't? ☐ YES ☐ NO
2. Do you have to strain or struggle to hear/understand conversations? ☐ YES ☐ NO

Function Screen

1. Do you need help with preparing meals, transportation, shopping, taking your meds, managing finances, or other activities of daily living? ☐ YES ☐ NO
2. Do you live alone? ☐ YES ☐ NO

Fall Screen

1. Have you had an injury from a fall in the last year? ☐ YES ☐ NO
2. Have you had more than one fall in the last year? ☐ YES ☐ NO

Home Safety Screen

1. Does your home have rugs, poor lighting, or a slippery bathtub/shower? ☐ YES ☐ NO
2. Does your home LACK grab bars in bathrooms, handrails on stairs or steps? ☐ YES ☐ NO
3. Does your home LACK functioning smoke alarms? ☐ YES ☐ NO

Advance Care Planning

Patient Consent: "I consent to discuss end-of-life issues with my healthcare provider." ☐ YES ☐ NO

_____ _____

Patient/Guardian Signature Date

Dr/NP _____

Location _____

Patient Name: _____ DOB: _____/_____/_____ Age: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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 at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐