Regional Primary Care, Inc.

# REGIONAL PRIMARY CARE

## Medicare Annual Wellness Visit

Name:_____________________________________________ DOB:________________ Today's Date:_________________

Date of Medicare Eligibility:___________________________ Date of Last Medicare Physical: ________________________

## MEDICATION LIST

| Prescription medications, Supplements, Over the Counter, Substances of Abuse | Dose and Frequency | Date Started | Date Stopped | Name of Provider who prescribes this medicine |
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## ALLERGY LIST

| Medication or Allergen | Type of Reaction |
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## REVIEW OF SYSTEMS (Check the box of any symptoms you are currently having.)

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| **GENERAL** | Appetite Change / Weight Gain / Weight Loss/ Fever / Chills / Sweats |
| **EARS** | Ringing / Hearing Loss / Infection / Drainage / Pain |
| **EYES** | Visual Changes / Double Vision / Eye Pain / Eye Discharge |
| **NOSE/THROAT** | Nasal Drainage / Sinus Pressure / Nosebleeds / Gum Bleeding / Tongue Soreness / Difficulty Swallowing / Hoarseness |
| **LUNGS** | Cough / Shortness of Breath / Wheezing / Coughing Up Blood / Known TB Exposure |
| **HEART** | Chest Pain / Skipping Beats / Rapid Heart Rate / Shortness of Breath with Exertion / Swelling in legs / Pain in Legs When Walking |
| **ABDOMEN** | Stomach Pain / Nausea / Vomiting / Diarrhea / Constipation / Black Stools / Blood in Stool |
| **URINARY TRACT – MEN** | Difficulty Urinating / Dribbling / Trouble Holding Urine / Up at Night to Urinate / Blood in Urine / Discharge From Penis / Erectile Dysfunction |
| **URINARY TRACT – WOMEN** | Difficulty Urinating / Trouble Holding Urine / Up at Night to Urinate / Blood in Urine / Abnormal Menstrual Periods / Menopause since :_____________ / Hysterectomy / Pelvic Pain |
| **ENDOCRINE** | Thyroid Trouble / Heat or Cold Intolerance / Diabetes / Excessive Thirst, Hunger, or Urination |
| **NEUROLOGIC** | Dizziness / Extremity Numbness or Weakness / Headache / Memory Loss / Seizures / Tremors / Loss of Consciousness / Loss of Function of arms or legs / Confusion |
| **EMOTIONAL** | Nervousness / Mood Swings / Depression / Anxiety / Difficulty Sleeping |
| **SKIN** | Brittle Hair or Nails / Hair Loss / Mole Changes / Rashes / Non-healing Lesions |
| **JOINTS/MUSCLES** | Backache / Pain in Joints / Joint Swelling / Pain in Muscles / Weakness / Neck Pain |
| **BLOOD/GLANDS** | Easy Bleeding/ Easy Bruising / Swollen Glands / Anemia |
| **IMMUNOLOGIC** | Contact Allergy (poison ivy) / Food Allergies / Seasonal Allergies |

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Name:_____________________________________________ DOB:________________ Today's Date:__________________

## CHRONIC MEDICAL CONDITIONS (Ongoing or Long-Term Problems like high blood pressure, diabetes, etc)

| Type of Problem | Approximate date of Onset | Managing Provider (If other) | Ongoing | Resolved |
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## MEDICAL/SURGICAL HISTORY

| Problem | Date of Surgery, ER Visit, etc. | Facility / Provider | Problems (if any) |
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## DIAGNOSTIC STUDIES (Indicate any lab tests, x-rays, MRI/CT, Mammogram, etc. that you have had since your last visit here that were ordered by another provider.)

| Name of Test | Date of Test | Ordering Provider | Where was Test Performed |
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## FAMILY HISTORY (Check to Indicate Positive History)

| | Self | Father | Mother | Sisters | Brothers | Aunts | Uncles | Daughters | Sons |
|---|---|---|---|---|---|---|---|---|---|
| Deceased | | | | | | | | | |
| Hypertension | | | | | | | | | |
| Heart Disease | | | | | | | | | |
| Stroke | | | | | | | | | |
| Kidney Disease | | | | | | | | | |
| Obesity | | | | | | | | | |
| Genetic Disorder | | | | | | | | | |
| Alcoholism | | | | | | | | | |
| Liver Disease | | | | | | | | | |
| Depression | | | | | | | | | |
| Colon/Rectal Cancer | | | | | | | | | |
| Breast Cancer | | | | | | | | | |
| Other Cancer | | | | | | | | | |
| Other | | | | | | | | | |

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## SOCIAL HISTORY

| Language/Communication Barrier: ☐ No ☐ Yes Explain: |
|---|
| Interpreter or Other Accommodation Provided Today: |
| Tobacco: ☐Never ☐Current ☐Prior Use Type (check): Cigarettes/ Cigars/ Pipe/ Chewing/ Vapor<br>Quit Date or Years of Use: ☐2nd Hand Exposure Amounts per Day: |
| Alcohol: ☐ Never ☐ Occasional ☐ Daily ☐ History of Alcohol Abuse (Please Describe): |
| Caffeine: ☐ Never ☐ Occasional ☐ Daily |
| Drug Abuse: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use<br>Please describe History of Abuse: |
| ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Occupation:<br>Exercise (Type and Frequency): |
| Home Environment: ☐ Private Home ☐ Assisted Living ☐ Other (Describe): |

## OTHER PROVIDERS OF CARE (Includes Specialists, Chiropractors, Therapists, In-Home Care, etc.)

| Provider Name | Type of Care | Date of Last Visit |
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## ACUTE PROBLEMS (New or short-term Problems. Example: Cough, injury, constipation, etc.)

| Type of Problem | Date of Onset | Managing Provider (if other) | Ongoing | Resolved |
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## Please do not write below this space.

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## PROVIDER USE ONLY

I have reviewed and/or noted all pertinent history and findings indicated above.

_____________________________________________________ ______________________________

**Provider Signature** **Date**