LOURDES MEDICAL ASSOCIATES

# Medicare Health Information Questionnaire

_____ **Initial Preventive Physical Examination - IPPE** (Welcome to Medicare Preventive Visit)
_____ **Annual Well Visit** (Annual Wellness Visit)
_____ **Subsequent Annual Well Visit** - SAWV

**Patients Story:** Married _____ Widowed_____ Divorced_____ Single_____
Living Arrangement: _____
Spouse/SO Name:_____
Children's Names: _____
Profession/Job: _____Pets:_____
Activities/Hobbies: _____

**Name:** _____ **Date of Birth:**_____

If you require assistance in filling out this form, please indicate who is helping you with it:

**Name of person:** _____ **Relationship:**_____

**How would you rate your overall health?**

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

**Your Healthcare Team: (OR Providers and Suppliers of Your Medical Care):**
Please list all providers and suppliers of your medical care such as primary care physicians, specialty physicians (e.g., eye doctor, cardiologist/heart doctor), and therapists). Please use back of page for additional team members.

| Team Member | Role | Contact Information |
|---|---|---|
| Family/Primary Care Doctor | Oversees all your healthcare needs | Name:<br>Phone Number: |
| Cardiologist | Monitors your heart | Name:<br>Phone Number: |
| Ophthalmologist/ Optometrist | Examines your eyes to prevent damage | Name:<br>Phone Number: |
| Endocrinologist | Manages diabetes and blood sugar control | Name:<br>Phone Number: |
| Dentist | Helps to keep your teeth and gums in good condition | Name:<br>Phone Number: |
| Nephrologist | Monitors your kidney health | Name:<br>Phone Number: |
| Gastroenterologist | Manages digestive health and performs colonoscopies | Name:<br>Phone Number: |
| **Other Healthcare team members** | **Role** | **Specialty** |
| | | Name:<br>Phone Number: |
| | | Name:<br>Phone Number: |

## Your past medical history:

| Current Medical Problems | Ongoing Regular Treatments (i.e., cancer, anemia, etc.) |
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**Medical and Surgical History**

| Past illnesses / Injuries / Surgeries/Treatments | Hospitalized (Where and Date) |
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## Your family medical history:

| Mother | Father | Brother | Sister |
|---|---|---|---|
| ☐ Cancer | ☐ Cancer | ☐ Cancer | ☐ Cancer |
| ☐ Heart Problems | ☐ Heart Problems | ☐ Heart Problems | ☐ Heart Problems |
| ☐ High Blood Pressure | ☐ High Blood Pressure | ☐ High Blood Pressure | ☐ High Blood Pressure |
| ☐ Diabetes | ☐ Diabetes | ☐ Diabetes | ☐ Diabetes |
| ☐ Depression | ☐ Depression | ☐ Depression | ☐ Depression |
| ☐ Dementia | ☐ Dementia | ☐ Dementia | ☐ Dementia |
| ☐ Other _____ | ☐ Other _____ | ☐ Other _____ | ☐ Other _____ |
| ☐ None of the above | ☐ None of the above | ☐ None of the above | ☐ None of the above |

**Current Medications:**
Please list all current medications you take, including over-the-counter medications, eye drops, vitamins and supplements. Please use the reverse side of the page if you take more medications/supplements.

| Medication name | Dose/amount | How often is it taken? |
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| **Do you take your medications in the way you were told to take them?** | | ☐ Almost always<br>☐ Sometimes<br>☐ Rarely<br>☐ Almost never |

**Do you have any allergies?** ☐ Yes ☐ No

**List:** _____

**Preventive Screening/Services:**
Please list the dates of your most recent screening/preventive health procedures, if known. If unknown please leave blank.

| Screenings/Services | Date Received |
|---|---|
| Flu Shot | |
| Pneumonia Shot 1 PVC13 | |
| Pneumonia Shot 2 PVC23 | |
| Tetanus Shot | |
| Shingles Shot | |

| Screenings/Services | Date Received |
|---|---|
| Colorectal Cancer<br>• Stool sample/FIT test<br>• Colonoscopy<br>• Cardiovascular screening<br>(total cholesterol, LDL, HDL) | |

**Females Only:**

| Services/Screenings | Date Received |
|---|---|
| Mammogram | |
| Pap Smear/Pelvic Exam | |
| Bone Density Scan | |

**Males Only:**

| Screenings/Services | Date Received |
|---|---|
| Abdominal Aortic Aneurysm Screening (Ultrasound of the abdomen) | |

**Depression Screening: (PHQ-2)**

| | |
|---|---|
| Over the past two weeks, has the patient felt down, depressed or hopeless? | ☐ Not at all<br>☐ Several days<br>☐ More than half the days<br>☐ Nearly every day |
| Over the past two weeks, has the patient felt little interest or pleasure in doing things? | ☐ Not at all<br>☐ Several days<br>☐ More than half the days<br>☐ Nearly every day |
| Have you noticed any problems with remembering things? | ☐ Not at all<br>☐ Several days<br>☐ More than half the days<br>☐ Nearly every day |
| ☐ **(OFFICE USE)** PHQ9 (If yes to any of the above) | Score _____ |

**Your Social and Emotional Support:**

| | |
|---|---|
| How often do you get the social and emotional support you need? | ☐ Almost always<br>☐ Sometimes<br>☐ Rarely<br>☐ Almost never |
| Do you have someone available to help you on an ongoing basis if you are sick and need help? | ☐ Yes<br>☐ No<br>☐ For a short time |

**Your Activities of Daily Living:**

| | | |
|---|---|---|
| Can you get to places that are not walking distance without help? (Example by taking a bus, taxi, or driving your own car) | ☐ Yes | ☐ No |
| Can you go grocery or clothing shopping without someone's help? | ☐ Yes | ☐ No |
| Can you prepare your own meals without someone's help? | ☐ Yes | ☐ No |
| Can you do your own housework without help? | ☐ Yes | ☐ No |
| Can you handle your own money without help | ☐ Yes | ☐ No |
| Can you use the telephone without someone's help? | ☐ Yes | ☐ No |
| Are you able to manage your medications without help? | ☐ Yes | ☐ No |
| Can you take care of personal care needs, such as eating, bathing, dressing and getting around the house without help? | ☐ Yes | ☐ No |

**Vision/Hearing**

| | | |
|---|---|---|
| Do you have trouble with your vision? | ☐ Yes | ☐ No |
| Do you have trouble with your hearing? | ☐ Yes | ☐ No |

**Home Safety**

| | | |
|---|---|---|
| Do you feel safe in your current living situation? | ☐ Yes | ☐ No |
| Have you been given any information about how to avoid safety hazards in your home? | ☐ Yes | ☐ No |
| Does your home have any of the following?<br>• Grab bars in the bathroom | ☐ Yes | ☐ No |
| • Hand rails on stairs | ☐ Yes | ☐ No |
| • Good/adequate lighting | ☐ Yes | ☐ No |
| • Secured/taped down rugs | ☐ Yes | ☐ No |

**Mobility/Falls**

| | | |
|---|---|---|
| Have you fallen in the past year?<br><br>If YES to above, how many times did you fall? _____ | ☐ Yes | ☐ No |
| Were you injured [if you fell]? | ☐ Yes | ☐ No |
| Do you ever feel unsteady when standing or walking? | ☐ Yes | ☐ No |
| Do you worry about falling? | ☐ Yes | ☐ No |
| Do you use a cane or walker? | ☐ Yes | ☐ No |

Provider assessment: If the above answers represent risk of falling, perform Get Up and Go Test.

Please mark with an (X)

No further evaluation needed _____
Get Up and Go Test Performed _____

**PROVIDER SIGNATURE**: _____

**Pain/Fatigue**

| | |
|---|---|
| Do you have trouble sleeping? | ☐ Almost never<br>☐ Sometimes<br>☐ Almost always |
| During the past two weeks, have you had pain that interferes with performing desired activities or doing things you enjoy? | ☐ Yes ☐ No |
| How often do you feel unusually tired? | ☐ Almost never<br>☐ Sometimes<br>☐ Almost always |

**Diet/Exercise**

| | |
|---|---|
| How would you rate your diet?<br>(e.g., enough servings daily of fruits and vegetables, lean meats etc.) | ☐ Excellent<br>☐ Very Good<br>☐ Good<br>☐ Fair<br>☐ Poor |
| Do you exercise 20 minutes a day, three or more days a week? | ☐ Yes ☐ No |

**Tobacco, Alcohol and Drug Use**

| | |
|---|---|
| Do you currently smoke? (includes cigarettes, cigars, pipes, electronic cigarettes) | ☐ Yes ☐ No |
| Do you use drugs other than those required for medical Reasons? | |
| **Males Only:**<br>How many times in the past year have you had 5 or more drinks in one day? | _____ times |
| **Females Only:**<br>How many times in the past year have you had 4 or more drinks one day? | _____ times |

**Advance Care Directive/Living Will**

| | |
|---|---|
| Do you have an Advance Care Directive or Living Will? | ☐ Yes ☐ No |
| If yes, who has a copy of it? | |
| 1. | |
| 2. | |
| 3. | |
| 4. | |

**Office Use:**

[ ] Information has been provided on how to prepare an Advanced Directive
[ ] Patient has been asked to provide a copy of Advance Directive to be scanned into the chart
**[ ]** Copy of Advanced Directive Attained
[ ] Patient has been asked to provide a copy of Medical Durable Power of Attorney
**[ ]** Copy of Medical Durable Power of Attorney Attained

| For Office Use Only: | | |
|---|---|---|
| Date of Visit: | Provider Seen: | Date of Last AWV, if any:: |
| Type of Wellness Exam: | ☐ G0438 AWV, initial visit | ☐ G0439 AWV, subsequent visit |

Subsequent AWV – annually at least 12 months after initial AWV

**Physician Signature:** _____ **Date:** _____