Name: ____ DOB: ___/___/______

Today: ___/___/______

Medicare Wellness Questionnaire

Diet

Your diet is: □ Well Balanced □ Unhealthy
The junk food you eat is: □ Limited □ Frequent
You eat this special diet: □ Low Carb □ Low Fat □ Low Salt

Other diet information: ____

Do you have problems with your teeth or with chewing?
□ No □ Yes, but the dentist is taking care of it □ Yes, and it is still a problem

Exercise

You exercise: □ Regularly □ Infrequently □ Not at all
You exercise approximately: ________ minutes per week
The type(s) of exercise you do:
____

Hearing Screen:

Do you wear hearing aids? □ Yes □ No
Do you have trouble hearing the television or radio when others do not? □ Yes □ No
Do you have to strain or struggle to hear/understand conversations? □ Yes □ No

Functional and Cognitive Impairment Screen:

Which of these do you need help with? □ None

□ Personal Hygiene/Grooming □ Self-feeding □ Bathing
□ Dressing/Undressing □ Moving to Bed/Toilet □ Ambulating
□ Using the Phone □ Transportation □ Shopping
□ Preparing Meals □ Doing Housework □ Doing Laundry
□ Managing Medications □ Managing Money

Is help available to you when you need it? □ Yes □ Sometimes □ No

Driving:

Do you drive? □ Yes □ Yes, with limitations □ No
Do you wear your seatbelt? □ Yes □ Yes, sometimes □ No

Fall Risk Screen:

Have you fallen more than once in the last year? □ Yes □ No
Do you have any difficulty with walking or balance? □ Yes □ No

Incontinence Screen:

Have you suffered from urinary incontinence this year? □ Yes □ No

Name: ____ DOB: ___/___/______

Today: ___/___/______

Medication Adherence:

Do you have trouble affording your medication? □ Yes □ No

Do you have difficulty taking your medications on schedule? □ Yes □ No

Home Safety Screen:

Which potential fall hazards exist in your home? □ None

□ Loose Rugs □ Uneven Floors □ Household Clutter

□ Poor Lighting □ No grab bars in the bathroom □ No handrails on the stairs

□ New/Unfamiliar surroundings

Patient Care Team - Please list the other providers you see:

Specialty	Group	Doctor Name
Eye Doctor		

Please list other adults who help you take care of your health (e.g. family members):

Name	Role/Relationship	Phone Number

Suppliers - Please list the suppliers of your medical goods:

Supply	Company
CPAP for sleep apnea	
Oxygen	
Nebulizer	
Diabetes Test Strips	

Advance Directives:

If you have Advance Directives, a Living Will, a Durable Power of Attorney for Healthcare or a Pennsylvania Order for Life Sustaining Treatment (POLST) please bring a copy to the office.

I certify that the information I have provided is complete and accurate.

_______________________________________ ____________________

Signature of Patient/Caregiver Date of Signature

Name: ____ DOB: ___/___/______

Today: ___/___/______

Mood Symptom Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Circle your answer)

0 = Not at all | 1 = Several days | 2 = More than half the days | 3 = Nearly every day

PHQ 9				
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Total _____	=	+__	+__	+__

0 = Not at all | 1 = Several days | 2 = More than half the days | 3 = Nearly every day

GAD 7				
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3
Total _____	=	+__	+__	+__

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
◻	◻	◻	◻

Name: ____ DOB: ___/___/______

Today: ___/___/______

Total Score Depression Severity for PHQ-9

1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Total Score Anxiety Severity for GAD 7

1-4	Minimal anxiety
5-9	Mild anxiety
10-14	Moderate anxiety
15-21	Severe anxiety

Elizabethtown Family Health Center:

Today's Date: ___/____/___

Name: ________________________________ **DOB:** ______/_______/______

LANGUAGE: ☐ English ☐ Spanish ☐ Other:_________________________
RACE: ☐ Declined ☐Caucasian ☐ African American ☐ Asian ☐Native American ☐Unknown ☐ Other:________________________
ETHNICITY: ☐Unknown ☐Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

PATIENT HEALTH HISTORY (check ALL that apply)

ALLERGIES: ☐ Yes / ☐ None to Medication / ☐ None to Food / ☐ None to Enviroment
If Yes, please list **all** allergies:
____
Do you have an allergy to LATEX? ☐Yes / ☐No

SOCIAL HISTORY

Marital Status: ☐ Married / ☐ Single / ☐ Divorced / ☐ Widowed
Tobacco Use: ☐ Never / ☐ Quit-Year?_________ / ☐ Yes-Packs per day?_______
If yes, what age did you start smoking? _________
Are you interested in getting help to quit? ☐ Yes / ☐ No
Alcohol Use: ☐ No / ☐Socially or Occasionally / ☐ Yes-drinks per week?_________

PERSONAL HEALTH HISTORY: Have you ever had…

High Blood Pressure ☐**Y** / ☐**N**
Thyroid Disease ☐**Y** / ☐**N**
Urinary Tract Infections ☐**Y** / ☐**N**
Kidney Disease/Stones ☐**Y** / ☐**N**
Depression/Anxiety ☐**Y** / ☐**N**
Unexplained weight loss ☐**Y** / ☐**N**
Frequent headache ☐**Y** / ☐**N**
Unexplained weight gain ☐**Y** / ☐**N**
A glaucoma tests ☐**Y** / ☐**N**
Fall w/an injury this year ☐**Y** / ☐**N**
Cancer ☐**Y** / ☐**N:** if yes:(type) ___________________________________

Diabetes ☐**Y** / ☐**N**
Osteoporosis ☐**Y** / ☐**N**
Constipation ☐**Y** / ☐**N**
High Cholesterol ☐**Y** / ☐**N**
Diarrhea ☐**Y** / ☐**N**
Liver Problems ☐**Y** / ☐**N**
Acid Reflux ☐**Y** / ☐**N**
Heart Disease ☐**Y** / ☐**N**
Low back pain ☐**Y** / ☐**N**
Other ☐**Y** / ☐**N** ______________________

Arthritis ☐**Y** / ☐**N**
Asthma ☐**Y** / ☐**N**
Anemia ☐**Y** / ☐**N**
COPD ☐**Y** / ☐**N**
Migraine ☐**Y** / ☐**N**
Gout ☐**Y** / ☐**N**
Cataracts ☐**Y** / ☐**N**

Family History: Does anyone in your family have the following… If so please list who beside:

☐ Alcoholism____________________
☐ Hypertension__________________
☐ Heart Disease__________________
☐ Liver Disease _________________
☐ High Cholesterol ________________
☐ Anemia/Sickle Cell _______________
☐ Thyroid Disease ☐_________________
☐ Bleeding Disorder________________

☐ Cancer ______________________
☐ Arthritis ______________________
☐ Depression____________________
☐ Obesity ______________________
☐ Seizures ______________________
☐ Diabetes ______________________
☐ Stroke ______________________
☐ Other: __________/______________

OPERATIONS: Check All that apply and give year (if known)

□Appendectomy ______ □Tonsillectomy _____ □Back Surgery_____
□Cataract (□**L** / □**R**)_____ □Gallbladder Removal _____ □Heart Bypass _____
□Hysterectomy (complete/partial) _____ □Hip Replacement (□**L** / □**R**)_____
□Knee Replacement (□**L** /□**R**) _____ □ Thyroid Surgery _____
□Other:____

Please list all your medications, including vitamins and herbal supplements:

1. 7.
2. 8.
3. 9.
4. 10.
5. 11.
6. 12.

* or provide list of medications w/ dosage

What is your pharmacy & location?

Pharmacy Name________________________ Location:________________________

Do you wear your seat belt? □**Y** / □**N** Do you exercise? □**Y** / □**N**
Over the past few months, have you ever…
felt down, depressed or hopeless? □**Y** / □**N**
felt little interest in doing things you enjoy? □**Y** / □**N**

WOMEN ONLY:

\# of Pregnancies: _______ # Children: ______ Miscarriages: _____
Age of Menopause (If Applicable): ________
Do you urinate frequently? □**Y** / □**N**
Does your bladder feel full, even after you have just emptied it? □**Y** / □**N**

65 YEARS AND OLDER ONLY:

Are you on a special diet? □**Y** / □**N**
If yes, why? ____
Do you have trouble hearing the TV or radio when others do not? □**Y** / □**N**
Do you have to strain to hear/understand conversations? □**Y** / □**N**
Do you need help with cooking, taking your meds or other activities? □**Y** / □**N**
Do you live alone? □**Y** / □**N**
Have you or any family member ever raised a concern about your memory? □**Y** / □**N**
Does your home have throw rugs, poor lighting or a slippery tub/shower? □**Y** / □**N**
Does your home have grab bars in the bathrooms? □**Y** / □**N**
Does your home have handrails on the stairs? □**Y** / □**N**
Does your home have functioning smoke alarms? □**Y** / □**N**
Do you have an advanced directive? □**Y** / □**N** *****If done by an attorney, please provide copy to office

We realize that this form is long, but, it allows us to provide better care for you so THANK YOU for participating in your care!