CalvertHealth Medical Group

ANNUAL MEDICARE WELLNESS VISIT

Please complete this packet as thoroughly as possible to help us better understand your overall health. This confidential history will be part of your permanent record.

Date: _____ Name: _____ Age: _____ DOB: _____
Phone Number: _____ Is it ok to leave a detailed message? ❑ Yes ❑No

Email Address: _____ Communication Preference: Email Phone Mail

Primary Care Provider: _____ Pharmacy: _____

Does someone help you with your health care? ❑Yes ❑No

Name: _____ Number: _____ Relationship: _____

MEDICAL HISTORY

Please list any allergies and what reaction you have:

Allergen	Reaction

Please list all medical conditions you have:

- ☐ Acid Reflux / GERD
- ☐ ADHD
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer: _____
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema / COPD
- ☐ Epilepsy / Seizures
- ☐ Glaucoma / Cataracts
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Memory Loss
- ☐ Osteoporosis
- ☐ Seasonal Allergies
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Other: _____

Patient Name: _____ DOB: _____

Please list any other providers you see. Including therapists, chiropractors, acupuncturists, dieticians, etc.:

Name	Specialty	Phone Number	Condition Treated
Ex: Dr. Varkey Mathew	Ex: Cardiologist	410-535-3612	Ex: High blood pressure

Please list all medications you take. Including vitamins, herbs, and any over-the-counter medications:

Medication	Dose	Instructions
Ex: Tylenol	Ex: 500mg	Ex: 1 pill 3 times a day

Please list any surgeries you have had:

Date	Type	Location
Ex: 01/01/01	Ex: Right knee replacement	Ex: Calvert Hospital

Patient Name: _____ DOB: _____

Please list any hospital visits you have had:

Date	Reason	Hospital	Admitted?
Ex: 01/01/10	Ex: Stroke	Ex: Calvert Hospital	Ex: Yes

Please list all current medical supplies and suppliers you use (Ex: respiratory aids, diabetic supplies, etc.):

Supplies	Supplier	Phone Number

FAMILY MEDICAL HISTORY

Does anyone in your family have any of the following? (Please "x" all that apply):

	Mother	Father	Brother	Sister	Son	Daughter
If deceased, what age were they?						
Alcoholism						
Alzheimer's / Dementia						
Anxiety or Depression						
Cancer: Breast						
Cancer: Colon						
Cancer:						
Cholesterol Disorder						
Diabetes						
Emphysema / COPD						
Genetic Disorder						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Liver Disease						
Obesity						
Stroke						
Thyroid Disorder						
Other:						

Patient Name: _____ DOB: _____

At preventative visits, we ask everyone to complete a variety of questionnaires. Some are sensitive in nature and may be difficult to discuss. We encourage you to answer as honestly as possible so that we can identify your needs. Our goal is to see how we might improve your overall health.

Tobacco Screening

Have you ever smoked or used other tobacco products?..... Yes No
If yes, what type? ..... Cigarettes Chew Cigars Snus Vape
Are you still smoking? ..... Yes No
If yes: For how many years? _____ # of packs a day: _____ Do you want help quitting?..... Yes No
If no: When did you quit: _____ How many years did you smoke: _____ # of packs per day: _____

Drug Screening

In the past year, have you used any illicit drugs or prescription medications not prescribed to you?.... Yes No
if yes, what type? (Check all that apply)

☐ Amphetamines	☐ Crack	☐ Heroin	☐ Opiates	☐ Psychotic Meds
☐ Barbiturates	☐ Ecstasy	☐ Inhalation	☐ Methadone	☐ Sleeping Pills
☐ Benzodiazepines	☐ Fentanyl	☐ K2	☐ Suboxone	☐ Methamphetamine
☐ Cocaine	☐ LSD	☐ Marijuana	☐ Pain Meds	☐ Other: _____

Alcohol Screening (Please circle your response)

	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	+ 4 times a week
How many drinks do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	+ 10
How often have you had 6 or more drinks on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
					TOTAL SCORE:

Patient Name: _____ DOB: _____

Depression Screening

In the last 2 weeks, how often have you been bothered by any of the following: (Please check the appropriate box)

	NONE (0)	SEVERAL (1)	+ HALF (2)	ALWAYS (3)
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling/staying asleep or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself, like a failure, or like you let yourself/family down	☐	☐	☐	☐
Trouble concentrating on things like reading or watching TV.	☐	☐	☐	☐
Moving or speaking so slowly that other people have noticed or being fidgety or restless	☐	☐	☐	☐
Thoughts that you would be better off dead or hurting yourself	☐	☐	☐	☐
				TOTAL SCORE:

How difficult have these problems made it for you to do your work, take care of things at home, or get along with others?

☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Social Needs Screening

What is your living situation today?

- ☐ I have a steady place to live
- ☐ I have a place to live today, but I am worried about losing it in the future
- ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside or in the street, on a beach, in a car, abandoned building, bus, or train station or in a park)

Think about the place you live. Do you have problems with any of the following? (Check all that apply)

- ☐ Pests such as bugs, ants, or mice
- ☐ Lead paint or pipes
- ☐ Oven or stove not working
- ☐ Water leaks
- ☐ Mold
- ☐ Lack of heat
- ☐ Smoke detectors missing or not working
- ☐ None of the above

Patient Name: _____ DOB: _____

Within the last year, you worried that your food would run out before you got money to buy more.

☐ Often true ☐ Sometimes true ☐ Never true

Within the last year, the food you bought just didn't last and you didn't have money to get more.

☐ Often true ☐ Sometimes true ☐ Never true

In the past year, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting the things needed for daily living?

☐ Yes ☐ No

In the last year, has the electric, gas, oil, or water company threatened to shut off services in your home?

☐ Yes ☐ No ☐ Already shut off

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

☐ Very hard ☐ Somewhat hard ☐ Not hard at all

Do you want help finding or keeping work or a job?

☐ Yes, help finding work ☐ Yes, help keeping work ☐ I do not need or want help

Do you speak a language other than English at home?

☐ Yes, _____ ☐ No

Do you want help with school or training? Example: job training, getting a diploma, GED or equivalent?

☐ Yes ☐ No

Because of a mental, physical, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

☐ Yes ☐ No

Because of a mental, physical, or emotional condition, do you have serious difficulty concentrating, doing errands alone such as visiting a doctor's office or shopping?

☐ Yes ☐ No

Patient Name: _____ DOB: _____

How often do you feel lonely or isolated from those around you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

How often does anyone, including family, friends, and caregivers, physically hurt you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

How often does anyone, including family, friends, and caregivers, insult or talk down to you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

How often does anyone, including family, friends, and caregivers, threaten you with harm?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

How often does anyone, including family, friends, and caregivers, scream or curse at you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

Health Risk Assessment

How does your health compare to most people your age?

☐ Great ☐ Good ☐ Fair ☐ Poor

With whom do you live?

☐ Spouse/Partner ☐ Assisted/Group ☐ Friend/Family ☐ Alone

1. Do you have trouble dressing, bathing, eating, using the toilet, or grooming? ☐ Yes ☐ No
2. Do you have trouble doing errands alone? ☐ Yes ☐ No
3. Do you have trouble making food, doing housework, using the phone, or driving? ☐ Yes ☐ No
4. Do you have trouble using your checkbook, paying bills, or taking medications? ☐ Yes ☐ No
5. Do you leak urine or soil your clothes? ☐ Yes ☐ No
6. Do you have serious difficulty walking or climbing stairs? ☐ Yes ☐ No
7. Have you tripped or fallen in the last year? ☐ Yes ☐ No
8. Do you have trouble keeping your balance? ☐ Yes ☐ No
9. Are you deaf or do you have trouble hearing? ☐ Yes ☐ No
10. Are you legally blind or do you have trouble seeing even with glasses? ☐ Yes ☐ No

11. Do you exercise on a regular basis?	☐ Yes	☐ No
12. Are you a victim of physical, sexual, or emotional abuse?	☐ Yes	☐ No
13. Have you felt unusual pain or fatigue in the last 14 days?	☐ Yes	☐ No
14. Have you felt stress, anger, or loneliness in the last 14 days?	☐ Yes	☐ No
15. If you live with someone, is that person in good health?	☐ Yes	☐ No
16. Are you sexually active?	☐ Yes	☐ No
17. Do you frequently use sugar, and salt or eat fatty or fried foods?	☐ Yes	☐ No
18. Do you frequently eat fruits, vegetables, fiber, and whole grains?	☐ Yes	☐ No
19. Do you take calcium or vitamin supplements?	☐ Yes	☐ No
20. Have you seen a dentist in the last year?	☐ Yes	☐ No
21. Do you use a seatbelt when driving or riding in a vehicle?	☐ Yes	☐ No
22. Do you use sunscreen when outside for long periods?	☐ Yes	☐ No
23. Does your home have rugs in the hallway?	☐ Yes	☐ No
24. Does your home have grab bars in the bathrooms?	☐ Yes	☐ No
25. Does your home have handrails on the stairs?	☐ Yes	☐ No
26. Does bending over cause dizziness or issues with balance?	☐ Yes	☐ No
27. Are you afraid to go out alone due to dizziness or issues with balance?	☐ Yes	☐ No
28. Are you or someone close to you worried about your memory?	☐ Yes	☐ No
29. Do you have trouble concentrating, remembering things, or making decisions?	☐ Yes	☐ No
30. Do you have a medical power of attorney or advanced directive?	☐ Yes	☐ No
31. If no, would you like to discuss setting one up?	☐ Yes	☐ No

_____

Patient Signature Date

_____

Provider Signature Date

_____

Clinical Support Staff Date

_____

Clinical Support Staff Date