Story Family Medicine

Medicare Wellness and Medical Health Review

Today's Date:_____

Name:_____Date of Birth_____ Primary ☐Home ☐Cell_____
Email:_____ (Mailing Address):_____
City State Zip

Health Insurance Information

Has your Health Insurance Plan changed? ☐Yes ☐No (If yes, please provide us with your new Insurance cards)

In Case of an Emergency

Name:_____Relationship ☐Spouse ☐Parent ☐Grandparent ☐Friend ☐Other:_____
Phone:_____ Are we able to disclose Medical Information with them? ☐Yes ☐No

Advanced Care Directives, Medical Wishes or Other Preferences

Do you have a Living Will? ☐ Yes ☐No
Are you an Organ Donor? ☐Yes ☐No
Do you have a DNR? ☐Yes ☐No
Do you have a Power of Attorney/Health Care Surrogate? ☐Yes ☐No
Name_____ Phone: _____

Health and Social History

Have you ever smoked/used tobacco products? ☐ Yes ☐ No (If Former smoker, when did you Quit?)_____
Do you currently smoke? ☐Yes ☐No (If you currently smoke, how many a day or week?) _____
Do you drink alcohol? ☐ Yes ☐ No (If yes, how often): _____Currently use recreational drugs? ☐Yes ☐No
Do exercise regularly? ☐ Yes ☐No (If yes, how often): _____ What type of exercise?_____
Nutritional Diets: ☐ Diabetic Diet ☐ Low Sodium ☐ Low Fat ☐ Low Cholesterol ☐ Other: _____
Do you have drug, environment or food allergies? ☐ Yes ☐ No(If yes, please list type and reactions)
_____

General Health Update and Medical History

Please list any providers that you see currently.

_____

Do you have any current health concerns that need further clarification? ☐ Yes ☐ No (If yes, please explain)

_____

Family History

	Mother	Father	Sibling	Other
Alcoholism	☐	☐	☐	☐ _____
Cancer	☐	☐	☐	☐ _____
Depression	☐	☐	☐	☐ _____
Diabetes	☐	☐	☐	☐ _____
Heart Disease	☐	☐	☐	☐ _____
Heart Issues	☐	☐	☐	☐ _____
Hypertension	☐	☐	☐	☐ _____

Procedures or Testing (List the Year Completed)

Diagnostic Tests:

Colonoscopy: _____
Bone Density: _____
Mammogram: _____
Chest Xray: _____
Chest CT: _____
EKG: _____
ECHO: _____
Stress Test: _____
AAA U/S: _____
Other: _____

Last Labs: _____
Eye Exam: _____
Foot Exam: _____
Pap/Breast Exam: _____
Prostate Exam/PSA: _____

Adult Immunizations:

Flu: _____
Pneumonia 23: _____
Prevnar 13 (Booster):_____
TDap: _____
MMR: _____
Zoster (Shingles):_____
Hep A:_____ Hep B:_____

Review of Symptoms or New Complaints

Head & Neck:
☐Headaches
☐Dizziness
☐Lightheaded
☐Memory Loss

Eyes:
☐Blurred Vision
☐Eye Pain
☐Worsening Sight

Oral:
☐Dry Mouth
☐Loss of Taste

Ears and Hearing:
☐Hearing Loss
☐Ringing in Ears
☐Wax Buildup

Nose & Throat:
☐Sneezing
☐Nose Bleeds
☐Runny Nose
☐Sinus Issues
☐Sore Throat

Respiratory:
☐Cough
☐Shortness of Breath
☐Wheezing

Cardiac:
☐Chest Pain
☐Blood Pressure
☐Palpitations

General Mood:
☐Anxiety
☐Depression
☐Mood Changes

Muscle/Joints:
☐Back Pain
☐Sore Muscles
☐Painful Joints
☐Foot Pain
☐Leg Pain

Urinary:
☐Burning
☐Frequency
☐Incontinence
☐Hesitancy

Neurological:
☐Confusion
☐Dizziness
☐Seizures
☐Numbness
☐Tingling
☐Tremors/Shaking
☐Poor Balance
☐Poor Coordination

Skin:
☐Rash/Hives
☐Itching
☐Bruising
☐Abnormal Growth