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