Medicare Initial Preventive Physical Examination Encounter Form

Patient to complete this side ONLY

Patients Name: _____ Date of Birth: _____ Chart #: _____

Medicare B Eligibility Date: _____ Date of Exam: _____ Date of Last Exam: _____

Medical/Social History

Past personal illnesses or injuries:

Injury or Illness	Date	Hospitalized?

Drug Allergies: _____

Alcohol Use: ___Yes ___No If so, how many? _____

Tobacco Use: ___Yes ___No If so, how many? _____

Drug Use: ___Yes ___No

Medications, Supplements & Vitamins:

Social History Notes (Including diet and physical activities):

Family History Notes:

DEPRESSION SCREEN:

Over the past two weeks, have you felt down, depressed or hopeless? _____ Yes _____ No

Over the past two weeks, have you felt little interest or pleasure in doing things? _____ Yes _____ No

FUNCTIONAL ABILITY/SAFETY SCREEN

*Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? (Circle all that apply) _____ Yes _____ No

* Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? _____ Yes _____ No

Hearing Evaluation: _____

(Explain if you have noticed any hearing difficulties)

A "yes" response to any of the questions regarding depression or function/safety should trigger further evaluation

List ALL medical providers with their name and specialty:

List ALL medical supplies/suppliers with name and numbers: