HEALTH QUESTIONNAIRE

______________________________ ______________ ______________
Patient Name Date of Birth Date

Date of last IPPE/AWV Exam:	_____Enhanced Services	______IPPE-Welcome to Medicare – Select G0402 (face to face), G0403(ECG/trac/i+p), (1 time during first 12 months on Medicare)	______Initial AWV w/PPPS – G0348 (1 time only after 1st 12 months of Medicare B elegibility AND 1 year after IPPE.)	______Subsequent AWV w/PPPS – G0349 (Annually at least 12 months after initial AWV w/PPPS)

Do you have any drug allergies? If yes, list and name drug(s) and what happened when you took it?

____
____
____

Pharmacy Name and Phone Number:________________________________

List all current medicines used daily or even weekly. Medicines that you used "as needed" at least twice in the last year should also be listed. Include over the counter medicines and supplements; including aspirin, calcium, vitamins and others.

Medication Name and Strength	How often	Aprox. Date Started	(Below for office use only) Date	Date	Date	Date

List surgeries, hospitalizations, injuries, accidents, and emergency room visits.
Returning patients, please update if there are any changes since your last physical.

Date	

List other providers (doctors, specialists, therapists, etc.) and healthcare suppliers (respiratory, visiting nurse, etc.).
Returning patients, please update if there are any changes since your last physical.

Name	Specialty	Phone number

FOR RETURNING PATIENTS ONLY, NOT NEW PATIENTS: Is there anything new in your medical history, changes or updates in social and/or family history since your last physical?

We want to know if you need help with any of the following, and who helps you. Check and fill in for each task.

Task	Don't Need Help	Need Help	If you need help who helps?
Feeding yourself	_____	_____	_____
Getting from bed to chair	_____	_____	_____
Getting to the toilet	_____	_____	_____
Getting dressed	_____	_____	_____
Bathing	_____	_____	_____
Using telephone	_____	_____	_____
Taking medication	_____	_____	_____
Preparing meals	_____	_____	_____
Managing money/ financial affairs/ checkbook	_____	_____	_____
Doing laundry	_____	_____	_____
Doing housework	_____	_____	_____
Shopping for food	_____	_____	_____
Driving	_____	_____	_____
Doing handyman work	_____	_____	_____
Climbing a flight of stairs	_____	_____	_____
Getting to places beyond walking distance	_____	_____	_____

Do you use a cane, walker, or wheelchair?

Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting?

Over the past few weeks, have you felt little interest or pleasure in doing things? NO___ YES___
Over the past 2 weeks, have you felt down, depressed or hopeless? NO___ YES___
Have you had previous problems with depression? NO___ YES___
Do you have any hearing or visual difficulties? NO___ YES___
Have you had any problems with your memory, or does a family member feel you have memory problems? NO___ YES___
Have you had any falls in the last year? NO___ YES___
Have you ever smoked cigarettes, pipe, cigar or chewed tobacco? NO___ YES___
What physical exercise do you regularly do?

Do you ever drink alcohol, including beer and/or wine? (check one)
a. _____ Daily
b. _____ Greater than 3 times a week
c. _____ 1-3 times a week
d. _____ Less than 1 time a week
e. _____ Never
During the last month, what is the greatest number of alcoholic drinks you have consumed in one day? _____
Have you ever felt you have to cut down on your drinking? NO___ YES___
Have people annoyed you by criticizing your drinking? NO___ YES___
Have you ever felt bad or guilty about your drinking? NO___ YES___
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? NO___ YES___
Do you, or did you use any illicit drugs i.e. marijuana, cocaine, stimulants, etc. or overuse any prescription drugs i.e. sleeping pills, narcotics, etc.? NO___ YES___
Describe a typical day's food and beverage consumption.

In the past 12 months, have you ever lost control of your urine or gotten wet? NO___ YES___
Do you always wear a seatbelt when you ride in the car? NO___ YES___
Describe your residence and who lives with you. Do you employ someone to help you in your home?
Are you currently working, retired; what has been your principal occupation?

How much school did you complete?
Do you have a Living Will (Advanced Directive) and Medical Durable Power of Attorney (healthcare proxy)? NO___ YES___
Please describe any military service.
How important is religion or spirituality in your life?

For physician use: problem/risk factor list updated including FH _____

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of the things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 – would **never** doze
1 – **slight** chance of dozing
2 – **moderate** chance of dozing
3 – **high** chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive, in a public place (eg, a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL SCORE	_____

_____ 0–10, _____ 10-12, _____ 12-24

Which medical conditions do you have now, or have you had in the past? (Check all that apply)

EYE AND EAR PROBLEMS

a. _____ cataracts
b. _____ glaucoma
c. _____ macular degeneration of the eye
d. _____ sinus disease
e. _____ other, specify:

LUNG PROBLEMS

a. _____ asthma
b. _____ bronchitis
c. _____ lung cancer
d. _____ emphysema
e. _____ history or exposure to tuberculosis or asbestos
f. _____ other, specify:

HEART PROBLEMS

a. _____ coronary bypass or stents
b. _____ atrial fibrillation
c. _____ coronary artery disease
d. _____ angina
e. _____ heart attack (year) _____
f. _____ heart failure
g. _____ passing out, fainting
h. _____ high blood pressure
i. _____ elevated cholesterol
j. _____ other, specify:

GASTROINTESTINAL PROBLEMS

a. _____ ulcers
b. _____ heartburn/hiatal hernia
c. _____ diverticulosis
d. _____ liver disease/ cirrhosis
e. _____ hepatitis
f. _____ polyps
g. _____ gallbladder disease
h. _____ other, specify:

BONE AND JOINT PROBLEMS

a. _____ arthritis
b. _____ osteoporosis
c. _____ fractured hip, wrist or spine
d. _____ gout
e. _____ Raynaud's
f. _____ morning stiffness
g. _____ other, specify:

KIDNEY AND URINARY PROBLEMS

a. _____ kidney disease
b. _____ prostate disease
c. _____ bladder or kidney infections
d. _____ blood in urine
e. _____ kidney stones
f. _____ other, specify:

GLAND PROBLEMS

a. _____ diabetes
b. _____ thyroid overactive (high)
c. _____ thyroid underactive (low)
d. _____ high calcium blood levels
e. _____ other, specify:

NERVOUS SYSTEM PROBLEMS

a. _____ stroke
b. _____ Parkinson's disease
c. _____ epilepsy/seizures
d. _____ neuropathy
e. _____ migraines
f. _____ other, specify:

OTHER HEALTH PROBLEMS

a. _____ anemia
b. _____ hernia
c. _____ thrombosis (blood clots)
d. _____ cancer, specify _____
e. _____ sexual function problem
f. _____ skin disease
g. _____ easy bruising or bleeding

Current Symptoms or Problems

To be certain that we've covered everything: during the last three months, have you had any of the following symptoms or problems? (Check all that apply)

EYE OR EAR PROBLEMS
- **a. _____ ringing in ears**
- **b. _____ vertigo or spinning**
- **c. _____ ear trouble**
- **d. _____ other eye problems**

HEART PROBLEMS
- **a. _____ chest pain or tightness**
- **b. _____ rapid or irregular heart beats/palpitations**

LUNG PROBLEMS
- **a. _____ persistent cough**
- **b. _____ difficulty breathing or shortness of breath**

BRAIN OR NERVOUS SYSTEM PROBLEMS
- **a. _____ frequent headaches**
- **b. _____ frequent dizzy spells**
- **c. _____ passing out or fainting**
- **d. _____ paralysis, leg or arm weakness**
- **e. _____ numbness or loss of feeling anywhere**
- **f. _____ serious problem with memory or difficulty thinking**
- **g. _____ tremor or shaking**

WOMEN'S PROBLEMS
- **a. _____ vaginal bleeding**
- **b. _____ vaginal discharge**
- **c. _____ breast lumps or discomfort**

DIGESTION PROBLEMS
- **a. _____ dental problems**
- **b. _____ difficulty swallowing**
- **c. _____ frequent indigestion or stomach discomfort/pain**
- **d. _____ frequent nausea/vomiting**
- **e. _____ change in bowel habits**
- **f. _____ weight loss - how many pounds? _____**
- **g. _____ black bowel movements or bleeding from rectum**
- **h. _____ frequent diarrhea**
- **i. _____ persistent constipation**

KIDNEY AND URINARY TRACT PROBLEMS
- **a. _____ urination at night**
- **b. _____ frequent urination**
- **c. _____ difficulty starting or stopping urination**

BONE AND JOINT PROBLEMS
- **a. _____ leg pain on walking**
- **b. _____ back or neck pain**
- **c. _____ joint pain or stiffness**
- **d. _____ foot problems**
- **e. _____ leg pain in bed**
- **f. _____ joint swelling**

OTHER HEALTH PROBLEMS
- **a. _____ difficulty with sleeping**
- **b. _____ falling, stumbling or balance problems**
- **c. _____ swelling feet or ankles**
- **d. _____ fever or sweats**
- **e. _____ other**

Family History

Please list all siblings and children:

Name	Age	Current health status	Health history

Please list your parents:

Name	Age	Current health status	Health history

Please list your grandparents:

Name	Age	Current health status	Health history

To the best of your knowledge, please list your parents' siblings and their children

Name	Age	Current health status	Health history