Medicare Wellness Checkup

Date: ______________ **Birthdate:** ______________
(mm/dd/yyyy) (mm/dd/yyyy)

Patient Name: ________________________________
(last name, first name, middle initial)

1750 12th Street
Hood River, OR 97031

Phone: 541-386-5070
Fax: 541-386-7190
Web: www.cgfm.com

1. During the past four weeks, how would you rate your health in general?

   Good
   Fair
   Poor

2. Do you exercise for about 20 minutes three or more days a week?

   Yes, most of the time
   Yes, some of the time
   No, I usually do not exercise this much

3. How often do you have trouble taking medicines the way you have been told to take them?

   I do not have to take medicine
   I always take them as prescribed
   Sometimes I take them as prescribed
   I seldom take them as prescribed

4. Are you having difficulties driving your car?

   Yes, often
   Sometimes
   No
   I do not use a car.

5. Do you always fasten your seat belt when you are in a car?

   Yes, usually
   Yes, sometimes
   No

6. How far can you walk without stopping to rest?

   I can't walk without help
   Less than 100 feet
   1 block
   Unlimited
   other ______________________________________

Please complete both sides

7. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis or drive your own car?) yes no

8. Can you go shopping for groceries or clothes without someone's help? yes no

9. Can you prepare your own meals? yes no

10. Can you meet your personal care needs such as eating, bathing, dressing, or getting around the house without help? yes no

11. Can you handle your own money without help? yes no

12. How often during the past four weeks have you been bothered by any of the following problems?:

	Always	Often	Sometimes	Seldom	Never
Falling or unsteady when standing					
Sexual problems					
Memory problems					
Trouble hearing					
Problems with teeth or dentures					
Problems using the telephone					
Tiredness or fatigue					

13. Does your family have concerns about your memory or ability to think? yes no

List other medical professionals you have seen in the past 12 months.

____

____

____

____

____

Please complete both sides

Adult Review of Systems

Date: ______________ **Birthdate:** ______________
(mm/dd/yyyy) (mm/dd/yyyy)

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Check ANY symptoms you've experienced in the last 6 months.:

Last Dental exam: __________ Last Vision exam: __________

General symptoms	None	Fever	Night sweats	Weight loss	Weight gain	Increased fatigue	
Head & Eyes	None	Eye pain	Headache	Loss of vision	Need glasses/ contacts		
Ear, Nose, & Throat	None	Ear pain	Allergies	Sinusitis	Hearing loss	Snoring	Daytime sleepiness
Cardio-vascular	None	Chest pain	Shortness of breath	Racing or irregular heartbeat	Difficulty breathing with exertion	Swelling of calves/ankles	Calf pain while walking
Respiratory	None	Cough	Coughing up blood	Increased phlegm	Shortness of breath	Wheezing	
Gastro-intestinal	None	Abdominal pain	Blood in stool or black stool	Loss of stool	Diarrhea or constipation	Nausea, vomiting, or indigestion	Trouble swallowing
Urinary	None	Blood in urine	Loss of urine	Pain with urination	Increased urination	Urinating at night	Incomplete emptying
Male only	None	Erectile dysfunction	Changes in urinary stream				
Female only	None	Abnormal or painful periods	Painful intercourse	Chronic pelvic pain	Abnormal vaginal discharge	PMS	**Last period:** ________
Musculo-skeletal	None	Muscle weakness	Muscle or joint pain	Morning stiffness	Severe joint pain		
Skin	None	Rash	Non-healing sores	Dry skin	Changes in moles		
Breast	None	Breast discharge	Breast pain	Breast lump			
Neurologic	None	Fainting	Seizures	Numbness	Dizziness	Tremors	Falls
		Weakness	Trouble walking	Headache	Severe memory problems		
Psychiatric	None	Depression	Crying	Poor sleep	Severe anxiety	High stress	
Endocrine	None	Diabetes	Hypothyroid	Hyperthyroid	Hot flashes	Hair loss	Heat or cold intolerance
Hematologic Lymphatic	None	Easy bruising	Swollen lymph glands	Easy bleeding			

Adult Health Screening Form

Date: ________________ (mm/dd/yyyy) **Birthdate:** ________________ (mm/dd/yyyy)

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NOTE: We request that you update this form at least once per year. If you have already done so, check here: ☐

Access to Food

In the last 12 months, did you and the people you live with worry that you would run out of food before you were able to get more? ☐ No ☐ Yes

In the last 12 months, did you and the people you live with run out of food before you were able to get more? ☐ No ☐ Yes

Tobacco Use

Do you currently smoke tobacco cigarettes or cigars? ☐ No ☐ Yes

If so, how much tobacco do you smoke per week? ____________________________

Do you use any other tobacco products including chew or e-cigarettes? ☐ No ☐ Yes

If so, how much tobacco do you consume per week? ____________________________

Alcohol Consumption

MEN: How many times in the past year have you had 5 or more drinks in a day? ☐ None ☐ 1 or more

WOMEN: How many times in the past year have you had 4 or more drinks in a day? ☐ None ☐ 1 or more

Alcohol: One drink = BEER 12 oz. beer; 5 oz. wine; 1.5 oz. liquor (one shot)

Recreational Drugs

How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons? ☐ None ☐ 1 or more

Note: Recreational drugs include methamphetamines (speed, crystal), cannibis (marijuana), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

Mood

PHQ2 (2015)

Over the past 2 weeks, how often have You been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐

Caffeine Use

Do you consume caffeine in coffee, tea, energy drinks, etc.? ☐ No ☐ Yes

If so, how much caffeine do you consume in a typical day? ____________________________