Pentucket Medical

General Information For Medicare Annual Well Visit

Please bring this form with you to your appointment.

Name: _____ DOB: _____

Please list **all** providers you see in the space below. (Examples include Optometrist, Podiatrist, Surgeon, etc.):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list **all** Durable Medical Supply companies you use. (Examples include companies that provide your CPAP machine, Oxygen, Wheelchairs):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list **all in-home** Visiting Nurse Agencies you use:

_____

_____

_____

_____

_____

Do you use any other home care services? (Examples include Elder Services and Meals-On-Wheels, IV Medication Administration):

_____

_____

_____

_____

_____

Please list the following preventive service (if any).

Service / Test	Date
Fecal occult blood (stool card test)	
Colonoscopy	
Glaucoma test	
Bone density (if applicable)	
PSA (if applicable)	
Flu shot	
Pneumonia shot	
Other vaccine(s):	

Please list any Medications/Supplements of Over the Counter Drugs you are using.

Name of Medication	Strength/Dose	Reason for Medication

Name: _____ DOB: _____

Past Medical History/Conditions/Disease. Please check all that apply.

	Unremarkable		Crohn's Disease		Hepatitis A		Thyroid Disorder
	Asthma		Chronic Renal Failure		Hepatitis B		Tuberculosis
	Atrial Fibrillation		Depression		Hepatitis C		Valvular Heart Disease
	Anemia		Diabetes, Type 1		Infertility		UTI-Recurrent
	Anxiety Disorder		Diabetes, Type 2		Kidney Disease		Varicose Veins/ Phlebitis
	Autoimmune Disorder		Diverticulitis		Kidney Stone		Abnormal Pap Smear
	Biliary Cirrhosis		DVT (blood clot)		Liver Disease		Breast Disease
	Blood Transfusions		GI Bleeding		MI (heart attack)		Breast Cancer
	Brain Tumor		GERD (acid reflux)		Neurologic Disorder		Cervical Cancer
	Cerebrovascular Disease		Hemochromatosis		Osteoarthritis		DES Exposure
	Cirrhosis		Hyperlipidemia		Osteoporosis		Gestational Diabetes
	CVA/Stroke		Hypertension		Peripheral Vascular Disease		RH Sensitized
	COPD		Hypothyroidism		PUD		Total Abdominal Hysterectomy
	Colon Cancer		Hyperthyroidism		Rheumatoid Arthritis		TAH and BSO
	Coronary Heart Disease		Seizure Disorder		Uterine Anomaly		

Surgical History

Surgeries / Hospitalizations	Year	Complications (if any)

Family History. Has anyone in your family had (check all that apply):

	Alcoholism		Anemia		Arthritis		Anesthesia Complications
	Anxiety		Asthma		Birth Defects		Blood Clots
	Blood Transfusions		Breast Cancer		Cervical Cancer		Colon Cancer
	Depression		Diabetes		Growth/ Development Disorder		Heart Attack
	Angina (chest pains)		High Blood Pressure (Hypertension)		High Cholesterol (Hyperlipidemia)		Mental Illness
	Osteoporosis		Seizure Disorders		Severe Allergies		Stroke
	Suicide Attempt		Bowel Disease		Heart Disease		Kidney/Bladder Disease
	Lung/Respiratory Disease		Liver Disease		Sexually Transmitted Disease		Ulcers
	Coronary Heart Disease Male before age 55		Coronary Heart Disease Female before age 65		Colon Cancer Father		Colon Cancer Mother
	Lung Cancer		Melanoma				
Other:							

Social History (check all that apply):

	Current Smoker
	Former Smoker
	Never Smoked
	Passive cigarette smoke—Yes
	Passive cigarette smoke—No

	Alcohol use—Yes
	Alcohol use—No
	Drug use—Yes
	Drug Use—No

	HIV/High risk—Yes
	HIV/High risk—No

	Regular exercise—Yes
	Regular exercise—No

	Domestic Abuse