FAMILY MEDICAL GROUP, P.A.

Welcome to Medicare Patient Questionnaire

Initial Preventive Wellness Visit (IPPE)

Patient Name: ______________________________ **Date:** ____________________

Complete this questionnaire and bring to your appointment.

SOCIAL HISTORY

Tobacco: ☐ **Current** **Type:** **Frequency:** ☐ **2nd Hand** ☐ **Never** ☐ **Prior Use** **Quit Date:**

VAPE: ☐ **Current** **Frequency:** ☐ **2nd Hand** ☐ **Never** ☐ **Prior Use** **Quit Date:**

Alcohol: ☐ **Never** ☐ **Occasional** ☐ **Daily** **History of Alcohol:** (*describe*)

Caffeine: ☐ **Never** ☐ **Occasional** ☐ **Daily** (*how many cups*)

Drug Abuse: ☐ **Never** ☐ **Occasional** ☐ **Daily** ☐ **Prior Use** **Quit Date:**
History of Drug Abuse: (*describe*)

Exercise: ☐ **Never** ☐ **Occasional** ☐ **Daily** **Type of Exercise:**

Diet: ☐ **Vegetarian** ☐ **Vegan** ☐ **Diabetic** ☐ **Low Salt** ☐ **Low Fat** ☐ **Low Carb** ☐ **Other** (*describe*)

Home Environment: ☐ **Private Home** ☐ **Assisted Living** ☐ **Other** (*describe*)

Occupation: **Primary Language:**

SOCIAL HISTORY - ROUTINE TASKS

Please indicate if you DO or DO NOT need help performing these routine tasks

For all ☐ Yes answers specify who helps

TASKS	NO	YES	WHO HELPS
Feeding yourself			
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing or showering			
Walking across the room (including using a cane or walker)			
Using the telephone			
Taking your medicines			
Planning or preparing meals			
Managing money (like keeping track of expenses or paying bills)			
Moderately strenuous housework such as doing laundry			
Shopping for personal items like toiletries or medicines			
Shopping for groceries			
Driving			
Climbing a flight of stairs			

Additional Comments: ____
____
____

Initial Preventive Wellness Visit Patient Questionnaire

Patient Name: ____ **Date:** ______________________________

FAMILY HISTORY

Use √ to indicate positive history

	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Alcoholism									
Breast Cancer									
Colon or Rectal Cancer									
Other Cancer									
Depression or Manic Depressive Disorder									
Diabetes									
Genetic Disorder									
Heart Disease									
Hypertension									
Kidney Disease									
Liver Disease									
Obesity									
Stroke									
Other *(specify)*									

MEDICAL HISTORY

Hospital Visits Since Your Last Appointment/Reason	Hospital Name	Attending Physician	Dates of Hospitalization	Past Surgeries, Dates, Reason and Any Complications

ALLERGY LIST

Allergies	Type of Reaction

MEDICATION LIST

If medications are listed somewhere else in chart indicate location (***Nursing Staff***):

Herbals, Supplements, Vitamins, Over The Counter Drugs, Substances of Abuse	Date Started	Date Discontinued	Prescribed Medications Dose, Frequency, Route	Date Started	Date Discontinued

Initial Preventive Wellness Visit Patient Questionnaire

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HEALTH MAINTENANCE Record the last year you had the following. If you do not know, leave the date blank.			
VACCINES	**Date**	**EXAM**	**Date**
Hepatitis A		Glaucoma screening	
Hepatitis B		Hearing screening	
Influenza (flu)		Hemoccult	
Pneumococcal (pneumonia)		Lipid Panel	
Shingles		Mammogram	
Tdap (tetanus, diphtheria, pertussis)		Nutritional Therapy Training	
EXAM		Pap Smear HPV test	
Abdominal Aortic Aneurysm Screening		Pelvic Exam Clinical Breast Exam	
Bone Density Measurement		Prostate Exam	
Breast and Ovarian Cancer Screening BRCA 1 & 2		PSA Test	
Cologuard		Rectal Exam	
Colonoscopy		Smoking Cessation Counseling/Treatment	
Dental Exam			
Diabetes Screening			
Echocardiogram			

FALL RISK	NO	YES
Have you fallen in the past year? (If yes, check √ the circumstances surrounding the fall)		
☐ Tripped over something		
☐ Lightheadedness or palpitations prior to falling		
Loss of consciousness?		
Injured?		
Needed to see a doctor?		
Able to get up on your own?		

ADVANCED DIRECTIVE
Do you have an Advanced Directive (living will)? ☐ Yes ☐ No (*if **No**, are you able to prepare one?*)

Patient questionnaire completed by patient? ☐ **Yes**
☐ **No** (*if **No**, please indicate who assisted you*) ______________________

Patient Signature ________________________________ **Date** ______________________

Nurse Initials:______________ **Date:** ______________

Provider Signature (*to indicate review/notation of patient questionnaire*) ______________________ **MD APRN**

FMG: 1/2020