

Dear Patient,

Thank you for scheduling your Welcome to Medicare Visit with us.

This visit will:

* introduce you to the preventive services covered by Medicare
* screen for depression
* assess your functional ability
* assess home safety measures
* provide you with a written checklist outlining recommended preventive measures.

You are not required to complete the “Welcome to Medicare” physical to participate in the Medicare program.

Please come prepared for your appointment:

* **Fill out the enclosed forms** and return to us at your visit or by email to ouremailaddress.com or via our web portal
* If you are unable to complete the forms in advance, please come to our office 45 to 60 minutes ahead of your appointment time to complete them. They are required by Medicare for this visit.
* **Bring your Medicare Insurance card** with you so that we may verify your eligibility for this visit.
* Be prepared with a **list of any concerns** you would like the physician to address.
* **Bring all current medications** or a list of them

There is no charge for the Welcome to Medicare visit.   
  
However, your physician may need to treat other acute and chronic health issues in addition to performing your wellness exam (the same appointment).

Charges for these separate services will be filed to Medicare and may result in out of pocket expense for you depending on your coverage for illness visits.

Sincerely,

The physicians and staff of (your practice) Telephone number

Your signature below indicates that you have read and understand that you will be financially responsible for the portion of your physical not covered by your insurance.

Signature Date

**Providers and Suppliers of Your Medical Care:**

### Please list all providers and suppliers of your medical care such as primary care physicians, specialty physicians, chiropractors, pharmacies, herbalists and therapists.

|  |  |
| --- | --- |
| **Primary Care Physician(s)** | **Specialty** |
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| **Other Physicians** | **Specialty, Chiropractor, Pharmacies, Therapist**  **,** |
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**Current Medications:**

**Please include prescriptions, over-the counter medications, vitamins and supplements.**

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| **Medication name** | **Dose** | **Route** | **Frequency** |
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**Medication Allergies:**

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| **Medication** | **Reaction** |
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**DAILY ASPIRIN USE**

#### Have you discussed taking a daily aspirin with your doctor?

Yes

No

**Your History:** Please check the appropriate box for the conditions as they apply to you:

# Medical History

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition** | **yes** | **no** | **Comments** |  |  | **Condition** | **yes** | **no** | **Comments** |  |  | **Condition** | **Yes** | **No** | **comments** |
|  | |  | |
| Allergies |  |  |  |  | | Depression |  |  |  |  | | Heart Attack  (Myocardial infarction) |  |  |  |
| Anemia |  |  |  |  | | Diabetes |  |  |  |  | | Nerve/muscle disease |  |  |  |
| Anxiety |  |  |  |  | | Emphysema |  |  |  |  | | Osteoporosis |  |  |  |
| Arthritis |  |  |  |  | | Reflux, Heartburn (GERD) |  |  |  |  | | Seizures |  |  |  |
| Asthma |  |  |  |  | | Glaucoma |  |  |  |  | | Sickle cell anemia |  |  |  |
| Blood transfusion |  |  |  |  | | Heart murmur |  |  |  |  | | Stroke |  |  |  |
| Cancer |  |  |  |  | | HIV/AIDS |  |  |  |  | | Substance abuse |  |  |  |
| Cataracts |  |  |  |  | | High Blood  Pressure (Hypertension) |  |  |  |  | | Thyroid disease |  |  |  |
| Heart  Failure (CHF) |  |  |  |  | | Kidney disease |  |  |  |  | | Tuberculosis |  |  |  |
| Clotting disorder |  |  |  |  | | Meningitis |  |  |  |  | | Ulcers |  |  |  |
| Chronic  obstructive lung disease (COPD) |  |  |  |  | |  |  |  |  |  | |  |  |  |  |

#### Other Medical History:

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**Surgical History: Female**

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| **Surgery** | **Yes** | **No** | **Comments** |  |  | **Surgery** | **Yes** | **No** | **Comments** |  |  | **Surgery** | **Yes** | **No** | **Comments** |
|  | |  | |
| Appendectomy |  |  |  |  | | Cosmetic surgery |  |  |  |  | | Joint replacement |  |  |  |
| Brain surgery |  |  |  |  | | C-Section |  |  |  |  | | Small intestine surgery |  |  |  |
| Breast Surgery |  |  |  |  | | Eye surgery |  |  |  |  | | Spine surgery |  |  |  |
| Gall Bladder Surgery (Cholecystectomy) |  |  |  |  | | Fracture surgery |  |  |  |  | | Tubal Ligation |  |  |  |
| Colon surgery |  |  |  |  | | Hernia  repair |  |  |  |  | | Heart Valve  Replacement |  |  |  |

**Surgical History: Male**

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| **Surgery** | **Yes** | **No** | **Comments** |  |  | **Surgery** | **Yes** | **No** | **Comments** |  |  | **Surgery** | **Yes** | **No** | **Comments** |
|  | |  | |
| Appendectomy |  |  |  |  | | Cosmetic surgery |  |  |  |  | | Prostate surgery |  |  |  |
| Brain surgery |  |  |  |  | | Eye surgery |  |  |  |  | | Small  intestine surgery |  |  |  |
| Heart Bypass |  |  |  |  | | Fracture surgery |  |  |  |  | | Spine surgery |  |  |  |
| Gall Bladder Surgery (Cholecystectomy) |  |  |  |  | | Hernia repair |  |  |  |  | | Heart Valve Replacement |  |  |  |
| Colon surgery |  |  |  |  | | Joint replacement |  |  |  |  | | Vasectomy |  |  |  |

**Other surgical history:**

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**Family History:** Please check the appropriate box of the conditions that apply to your blood relatives:

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|  | **Father** | **Mother** | **Sister** | **Brother** | **Aunt** AuAu**Daughter** AuAunt**Daughter Daughter** | **Uncle** | **Daughter** | **Son** |
| **Alive** |  |  |  |  |  |  |  |  |
| **Deceased** |  |  |  |  |  |  |  |  |
| **Alcohol abuse** |  |  |  |  |  |  |  |  |
| **Arthritis** |  |  |  |  |  |  |  |  |
| **Asthma** |  |  |  |  |  |  |  |  |
| **Birth Defects** |  |  |  |  |  |  |  |  |
| **Cancer** |  |  |  |  |  |  |  |  |
| **Chronic Obstructive**  **lung disease (COPD)** |  |  |  |  |  |  |  |  |
| **Depression** |  |  |  |  |  |  |  |  |
| **Diabetes** |  |  |  |  |  |  |  |  |
| **Drug Abuse** |  |  |  |  |  |  |  |  |
| **Early Death** |  |  |  |  |  |  |  |  |
| **Hearing Loss** |  |  |  |  |  |  |  |  |
| **Heart Disease** |  |  |  |  |  |  |  |  |
| **High Cholesterol** |  |  |  |  |  |  |  |  |
| **Hypertension** |  |  |  |  |  |  |  |  |
| **Kidney Disease** |  |  |  |  |  |  |  |  |
| **Learning Disability** |  |  |  |  |  |  |  |  |
| **Mental illness** |  |  |  |  |  |  |  |  |
| **Mental Retardation** |  |  |  |  |  |  |  |  |
| **Miscarriages** |  |  |  |  |  |  |  |  |
| **Stroke** |  |  |  |  |  |  |  |  |
| **Vision loss** |  |  |  |  |  |  |  |  |

**comments:**

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**Social History:**

**Alcohol Use**

Yes No

**If Yes:** number of drinks per week

If Yes: type(s) of alcoholic beverages

### Sexually Active

Yes No Not currently

**If Yes:** Circle appropriate responses

Partner(s)**:** Male Female

**If Yes:** Birth control/Protection used

### Drug Use

Yes No

**If Yes**: number of times used per week

**If Yes:** list type(s) of recreational drugs used

### Tobacco Use

Yes No

#### Complete appropriate responses below:

Current Every Day Smoker? Number of packs per day Number of Years

Current Smoker? (not daily) Number of packs per week Number of Years

Former Smoker? Quit date

Passive Smoker?

Are you ready to Quit? Yes No

### Smokeless Tobacco Use

Yes No

#### Complete appropriate responses below:

Former User?

Never Used

Quit date

Are you ready to Quit? Yes N