Name: ______________________ Date of Birth: ____________ Date of Visit: ____________

Montgomery Internal Medicine Group
Wellness Visit Questionnaire

Please print this questionnaire, complete it, and bring it with you to your Annual Wellness Visit.

DEMOGRAPHIC INFORMATION:

Address ____

Home phone ____________ Cell phone ____________ Email ____________

ALLERGIES:

Name of Medication/Allergen	Type of reaction

MEDICATIONS (Include prescriptions, over the counter medications, supplements and vitamins):

Name of medication/supplement	Dose	Frequency

MEDICAL HISTORY (Current and Past):

Illness	Date	Treatment

SURGICAL HISTORY/HOSPITAL STAYS:

Surgery	Date	Hospital

Name: ______________________________________ **Date of Birth:** _______________ **Date of Visit:** _______________

FAMILY HISTORY:

Mother: Alive _____ Deceased _____ at what age _____ Illnesses/Cause of death: ______________________________

Father: Alive _____ Deceased _____ at what age _____ Illnesses/Cause of death: ______________________________

Other Pertinent Family History: ____

TOBACCO USE:

Are you a:

_____ Current every day smoker _____Current some days smoker _____ Former smoker _____ Heavy tobacco smoker
_____ Light tobacco smoker _____ Never a smoker _____ Passive smoke exposure/Never smoker

Quit date: _____ Packs per day: _____ Years a smoker: _____

SMOKELESS TOBACCO USE:

Are you a:

_____ Current user _____ Former user _____ Never a user _____ Quit date _____

ALCOHOL USE:

Do you drink alcohol _____ Yes _____ No

Drinks per week: _____ Wine _____ Beer _____ Hard Liquor

ILLICIT DRUG USE:

Never _____Occasionally _____Daily _____ Prior Use _____ Quit Date _____

CARE TEAM (List all providers that care for you, including your dentist):

Name	Specialty	Date of Last Visit

Name: ______________________________________ **Date of Birth:** _______________**Date of Visit:** _______________

SELF ASSESSMENT:

In general, would you say your health is?

_____ Excellent _____ Very Good _____ Fair _____ Poor

How often do you get the social and emotional support you need?

_____ Always _____ Usually _____ Sometimes _____ Rarely _____ Never

Are you having trouble with your hearing? _____ Yes _____ No
Are you having trouble with your vision? _____ Yes _____ No
Do you or a family member feel you are having difficulty remembering things? _____ Yes _____ No

RISK FOR FALLS SCREEN:

Have you had any falls in the past year? _____ Yes _____ No
If so, how many? _______
Have you injured yourself during the fall/s ? _____ Yes _____ No
Are you afraid of falling? _____ Yes _____ No

PHYSICAL ACTIVITY:

How many days a week do you usually exercise? _____Days/week

NUTRITION:

On a typical day, how many servings of fruit and/or vegetables do you eat? ________ Servings per day
On a typical day, how many servings of high fiber or whole grain foods do you eat? ________ Servings per day
On a typical day, how many servings of milk products do you consume? ________ Servings per day
Do you have tooth or dental problems that make it difficult to eat? _____Yes _____ No

ACTIVITIES OF DAILY LIVING:

Are you able to:

Dress yourself ___ Yes ___ No
Bathe yourself ___ Yes ___ No
Manage stairs ___Yes ___ No
Use the phone ___ Yes ___ No
Do housework by yourself ___ Yes ___ No
Prepare meals by yourself ___ Yes ___ No

Do laundry ___ Yes ___ No
Manage your medications ___ Yes ___ No
Handle your money ___ Yes ___ No
Shop by yourself ___ Yes ___ No
Travel ___ Yes ___ No

HOME SAFETY:

Does your home have:

Good lighting near doors, stairs and hallways ___ Yes ___ No
Clutter free floors and stairs ___ Yes ___ No
Sturdy handrails on all stairs ___ Yes ___ No
Grab bars present in bath areas ___ Yes ___ No
Non-slip bath mats ___ Yes ___ No
Non-slip carpets and throw rugs ___ Yes ___ No
Working smoke detectors ___ Yes ___ No
Working carbon monoxide detectors ___ Yes ___ No

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DEPRESSION:

Over the past 2 weeks, how often have you experienced the following:

Feeling down, depressed, or hopeless?

_____ 0=Not at all _____ 1=several days _____ 2=more than half the days _____ 3=nearly every day

Little interest or pleasure in doing things?

_____ 0=Not at all _____ 1=several days _____ 2=more than half the days _____ 3=nearly every day

ADVANCED DIRECTIVES:

Do you have a Living Will, Health Power of Attorney or POLST form? _____ Yes _____ No

Patient's Signature: ______________________________ **Date:** __________

Welcome to Medicare Visit (G0402) ______ Annual Wellness Visit (G0438) _____ Subsequent Wellness Visit (G0439) _____