Schodack Internal Medicine and Pediatrics
Medicare Wellness-Annual

Please Fill out this form (or have your caregiver complete it) and discuss with your medical provider. Thank you!
Please Mark the preferred phone number you want use to contact you.

Patient Name: _____ Date of Birth: _____
☐ Home Phone: _____ ☐ Cell Phone: _____ ☐ Work Phone: _____
Address:_____ City: _____ State: _____ Zip_____

Pharmacy: _____ Phone _____
Address:_____ City: _____ State: _____ Zip_____
Mail Order Pharmacy: _____

Current Concerns/ Changes in Surgical history/ Changes in Family History?: _____

Review of Systems: Do you currently have concerns with any of the following?

Vision Problems	Yes	No	Leg Swelling	Yes	No	Muscle/Joint Pains	Yes	No
Hearing Problems	Yes	No	Leg pain with walking	Yes	No	Memory Problems	Yes	No
Headaches	Yes	No	Abdominal Pain	Yes	No	Depression	Yes	No
Dizziness	Yes	No	Heartburn	Yes	No	Anxiety	Yes	No
Chest Pain	Yes	No	Difficulty Swallowing	Yes	No	Urine Incontinence	Yes	No
Palpitations/ Irregular pulse	Yes	No	Constipation	Yes	No	Frequent Urination	Yes	No
Shortness of Breath	Yes	No	Recurrent Diarrhea	Yes	No	Blood in Urine	Yes	No
Persistent Cough	Yes	No	Blood in stool	Yes	No	Snoring	Yes	No
Unintentional Weight Loss/ Weight Gain	Yes	No	Night Sweats/ Fever	Yes	No	Loss of Sex Drive	Yes	No
			Skin Problems	Yes	No			

Name:_____ Date of Birth: _____

PHQ-9

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+
		TOTAL:		

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

Alcohol: One Drink =  12oz of Beer  5oz Wine  1.5 oz liquor (one shot)

	None	1 or more
Males: How many times in the past year have you had 5 or more drinks in a day?		
Females: How many times in the past year have you had 4 or more drinks in a day?		

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

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

Patient signature: _____

Provider signature: _____Date: _____

Name:_____ Date of Birth: _____

Name: _____ Phone number: _____

Preferred Language: _____ Best time to call: _____

		YES / NO
	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	Y N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y N
	Do problems getting **child care make it difficult for you to work** or study? *(leave blank if you do not have children)*	Y N
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	Y N
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	Y N
	Do you ever need help **reading hospital materials?**	Y N
	Are you **afraid you might be hurt** in your apartment building or house?	Y N
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N
	**Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight	Y N

Patient signature: _____

Provider signature: _____

Date: _____

Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Patient signature:_____ Date:_____

Provider signature:_____ Date:_____

Name:_____ Date of Birth: _____

Please Check: **Currently** Every Day Smoker _____ I smoke_____ pack(s) per day for _____ years
*Are you interested in quitting smoking? Yes No
Former Smoker _____ Quit Date _____ _____ pack(s) per day for _____years
Never a smoker

Have you seen a dentist in the past 12 months? Yes No

Exercise: I exercise _____ times per week. Type of Exercise_____
Or I rarely Exercise

Diet: I try to eat healthy or My diet needs improvement (please circle)

Describe Diet (How much fast food, avoid meat, fat, salt, sugar etc) _____

Self-Assessment
Considering your age, how would you describe your overall health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

How much difficulty, if any, do you have walking a ¼ mile which is about 2 or 3 blocks?
□ No Difficulty At All □ A Little Difficulty □ Some Difficulty □ A Lot Of Difficulty □ Not Able To Do It

Do you have trouble hearing the television or radio when others do not?	Yes	No
Do you have to strain or struggle to hear/ understand conversation?	Yes	No
Do you use a hearing aid?	Yes	No
Have you ever had a blood transfusion?	Yes	No
Do you always wear a seat belt in a car?	Yes	No

LEVEL OF SAFETY
Please check any of the following activities with which you need assistance:

_____ Using the phone	_____ Transportation	_____ Shopping
_____ Preparing meals	_____ Doing housework	_____ Doing laundry
_____ Managing medications	_____ Managing money	_____ Eating

Do you live alone? YES NO If no, who do you live with? _____

Do you have any current or past issues with domestic violence? Yes No Unsure

Look around your home; do you have any of the following?

_____ Loose rugs	_____ Uneven floors	_____ Household clutter	
_____ Poor lighting	_____ Stair handrails	_____ Smoke detectors	_____ Grab bars in bathroom

Advance Directives: If you have a Health Care Proxy and/or Advance Directives, please give a copy to office

Are you interested in receiving information on Advance Care Planning Yes No

Name:_____ Date of Birth: _____

Do you have a caregiver? Yes No If yes: Name: _____ Phone: _____

Relationship: _____

Please list any Specialist that you see:

	Name of Doctor	Last Visit
Podiatry (Foot Doctor)		
Ophthalmology (Eye Doctor)		
Cardiology		
Orthopedics		
Gastroenterology		
Nephrology (Kidney)		
Urology		
Psychiatry (Prescribes Meds)		
Psychology (Talk Therapy)		
Rheumatology		
Endocrinology		
Allergist		
Gynecology		
ENT (Ear/Nose/Throat)		
Oncology/Hematology		
Pain Management		
Other		

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