RRFM Document #MEDPAC2025 Name / Acct #:_____

DOB:_____/_____/_____

Patient Name: _____ **Date:** _____

Dear Patient, We want you to receive health care that may lower your risk of illness or injury. Medicare pays for some of this care at 100% but might not pay for all the wellness care you might need at the 100% level. While Medicare does not pay 100% for a traditional, head-to-toe wellness visit, it does pay for a limited wellness screening once a year to identify health risks and help you reduce them.

At your wellness visit, our health care team will take a complete health history and provide several other services including: Screenings to gauge cognitive impairment, risk for falling, and other problems

- A physical exam to evaluate your skin, blood pressure, height, weight, and anything else necessary for your age, gender, and level of activity
- Recommendations for other wellness services and healthy lifestyle changes

Please complete the questions below to help your provider identify your risk factors and get an accurate list of your current specialty healthcare providers.

Please list any specialist you are currently seeing:

Cardiologist: _____

Orthopedist: _____

Hematologist/Oncologist: _____

Gastroenterologist: _____

Allergist: _____

Ophthalmologist: _____

Endocrinologist: _____

Pulmonologist:

_____

Dermatologist: _____

Have you had any feelings of depression in the last two weeks? **YES** **NO**

Have you recently had a fall or experienced an injury in the home? **YES** **NO**

Do you feel like you need help with daily activities around the house (i.e. housework, managing money, or preparing meals)? **YES** **NO**

Have you experienced any hearing problems? **YES** **NO**

Have you experienced any vision problems? **YES** **NO**

RRFM Document #MEDPAC2025 Name / Acct #:_____

DOB:_____/_____/_____

Patient Medical History

Please indicate if you currently have or have had any of the following:

	Yes	No	Details		Yes	No	Details
Headaches, Migraines				Abdominal Pain			
Epilepsy, Seizures				Bowel Irregularity			
Depression				Rectal Bleeding			
Anxiety				Hemorrhoids			
Mental Health Issues (list specifics)				Hernia			
				Gallbladder Disease			
Insomnia				Bladder Infections			
Sleep Apnea				Incontinence			
Hearing Loss				Prostate Problems			
Ringing in Ears				Kidney Disease			
Glaucoma/ Cataracts				STD			
Fatigue				HIV/AIDS			
True Food Allergies				Hepatitis			
Stroke				Sexual Dysfunction			
Eating Disorders				Menstrual Dysfunction			
Thyroid Disease				Infertility			
Dizziness/Fainting				Arthritis			
Weakness				Osteoporosis			
Chest Pain				Neck Pain			
Heart Murmur				Back Pain			
Heart Palpitations				Bursitis/Tendonitis			
Heart Disease				Hives			
Elevated Cholesterol				Chronic Rash			
High Blood Pressure				Diabetes			
Low Blood Pressure				Cancer			
Circulation Problems				Weight Loss			
Bleeding Tendency				Weight Gain			
Anemia				Measles			
Blood Transfusion				Mumps			
Leg Pain/Swelling				Chickenpox			
Shortness of Breath				Whooping Cough			
Wheezing				Polio			
Asthma				Tetanus			
Pneumonia				Erectile Difficulties			
Tuberculosis (TB)				Any Other Illnesses/Diseases			
Indigestion/Heartburn							
Ulcer							

Printed Name: _____ Date: _____

See Next Page

RRFM Document #MEDPAC2025 Name / Acct #:_____

DOB:_____/_____/_____

Social History

	Yes	No	Details		Yes	No	Details
Smoke (list # per day and for how many years)				Caffeine Use (how much)			
Alcohol (list frequency and amount)				Exercise Outside of Daily Activities (what/how often/how long)			
Use Drugs				Employed (list occupation)			
Live Alone				Under Stress			
Have Children (how many/sex/birth year)							

Surgical History

	Yes	No	Details		Yes	No	Details
Tympanostomy (ear tubes)				Hysterectomy			
Appendectomy				Hip Replacement			
Gallbladder Surgery				Knee Surgery			
Heart Surgery (indicate what type)				Cataract Repair			
Tonsillectomy				Sinus Surgery			
Bunionectomy				Any Surgeries Not Listed (include only date and year or surgery)			
Back Surgery							

Family History

If yes to any below, please include which family member

	Yes	No	Details		Yes	No	Details
Asthma				Epilepsy			
Heart Disease (note age of first event)				Bleeding Disorder			
High Blood Pressure				Kidney Disease			
High Cholesterol				Thyroid Disease			
Stroke				Mental Illness			
Cancer (type, age)				Osteoporosis			
Glaucoma				Arthritis			
Diabetes				Any Other Illness/Disease Not Listed			

Printed Name: _____ Date: _____

See Next Page

Name / Acct #:_____

DOB:_____/_____/_____

Females Only

	Yes	No	Details		Yes	No	Details
Age Periods Began				Premature			
Cycle Length (average # days from first day of period to first day of next period)				Stillbirths			
Period Length				Miscarriages			
Flow				Abortions			
Discomfort				Tubal Pregnancy			
PMS (pre-menstrual syndrome)				Pregnancy Complications			
Number of Pregnancies				Vaginal Deliveries (what year/s)			
Full term				Cesarean Sections (what year/s)			

Medications

Please list any medications you are currently taking:

_____

_____

_____

_____

_____

Please list any known drug allergies you have and your reaction to them:

_____

_____

_____

_____

_____

Printed Name: _____ Date: _____