



## Established Patient Medicare Wellness Check-in Form

What are your concerns today?

1. \_\_\_\_\_
2. \_\_\_\_\_

**Since you last saw your Primary Care Provider:**

Please list any changes that have occurred in your overall health.

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Please list any new prescriptions, over the counter medications or supplements that have been started.

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Please list any new allergies to medications.

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Please list any new changes in your living situation.

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Please list any new medical problems in your family.

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Please list any recent surgeries or Emergency Room visits that have not been discussed with your provider.

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Please list any other providers you have seen.

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