Annual or Initial Medicare Examination

Name:_____ DOB:_____

Have you had your Welcome to Medicare examination? If so, when? _____

- How long have you been on Medicare? _____

Medications:

List all or your current medications, include any supplements.

Name of medication	Dosage	Reason for taking

Who are your current Providers and Pharmacy?

List your current physicians and or providers and their phone number

Name	Specialty	Phone Number

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List your current pharmacy/pharmacies

Name Pharmacy	Phone Number	Fax Number	Medication

List any other suppliers (for equipment, hearing aids, oxygen etc.)

Name	Phone number	Fax number

Diet and Exercise

Circle any that apply

Do you follow any particular diet? Yes No

- Low salt, Low fat, 1200 calorie diet, 1500 calorie diet, 1800 calorie diet, 2000 calorie diet, Mediterranean diet, DASH diet,

Other diet: _____

Do you exercise regularly? Yes No

- If yes, how often _____

History

Circle the correct answer or any that apply

Do you smoke? Yes No

Have you ever smoked? Yes No

- If yes, how much did you smoke?
- If yes, when did you quit?

Does anyone in the household smoke?

- If yes, are they trying to quit? Yes No

Do you use alcohol? Yes No

Describe: _____

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Hearing

Do you have any hearing difficulties? Yes No

- If yes describe_____

Do you use hearing aids? Yes No

- If yes, which ear? Right, Left or both
- Are they effective? _____

General activities and safety

Do you use glasses? Yes No

- Do you use glasses for reading or for distance

Do you need help to take your medicine? Yes No

- If you answered yes, who helps you? Include name and relationship.

Do you live alone? Yes No

Do you live in your own home, an apartment, Assisted Living, Adult family home or other

Do you drive? Yes, No

- If not, who drives you to appointments? Include name and relationship.
- Phone number: _____

Do you need help to manage your financial affairs, check book? Yes No

- If yes, who helps you? Include name and relationship_____

Do you need any assistance with activities of daily living? Yes No

If yes, complete the safety assessment detail below. If no, skip to page 4.

Safety Assessment Detail

Do you need help using the telephone? Yes No

- If yes, who helps you? Include name and relationship_____
- What kind of telephone assistance do you need? _____

Do you need help to prepare your meals? Yes No

- If yes, who helps you? Include name and relationship_____

Do you need help to do the laundry? Yes No

- If yes, who helps you? Include name and relationship_____

Do you need help to shop for groceries? Yes No

- If yes, who helps you? Include name and relationship_____

Do you do your own home repairs? Yes No

- If not, who helps you? Include name and relationship_____

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Falls or Emergency Room visits:

Circle the correct answer or any that apply.

Have you had any falls in the last 3 years? Yes No

- If yes, describe what happened _____

Are you having any issues with balance? Yes No

- If yes, describe: _____

Are you having any difficulties walking? Yes No

Do you require assistance to walk? Yes No

If yes, do you use a cane, walker or wheelchair? Circle which applies.

Have you had any Emergency Room visits in the last 3 years? Yes No

- If yes, describe why _____

Have you been admitted to the hospital in the last 3 years? Yes No

- If yes, what was the reason for admission to the hospital.

_____

Do you have an advanced directive? Yes No

Do we have a copy of your advanced directive? Yes No

- Any special instructions your provider should be aware of? _____