NEUSE VALLEY INTERNAL MEDICINE
MEDICARE WELLNESS VISIT

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Last name	First	Middle	Birth date

For office use: IPPE MAWV SAWV

Social Habits

Do you smoke? Y N If yes, how many daily? _____

Have you ever smoked? Y N If yes, quit date _____

Do you drink alcohol? Y N If yes, how many drinks per week? _____

Do you exercise? Y N If yes, how often_____

Functional Ability			**Safety**		
Do you need help with any of the following	Y	N	Living environment (circle one) Private home Apartment Assisted Living Nursing facility		
Bathing	☐	☐		Y	N
Dressing	☐	☐	Do you live alone	☐	☐
Walking	☐	☐	Do you have functioning smoke alarms	☐	☐
Housework	☐	☐	Do you have throw rugs, poor lighting or slippery shower	☐	☐
Managing your medications	☐	☐	Do you have grab bars or handrails	☐	☐
Managing your Money/paying bills	☐	☐	Do you have dizziness or balance problems	☐	☐
Transportation	☐	☐	Have you fallen in the past 12 months	☐	☐
Shopping	☐	☐			

Additional Screening

In the past few weeks have you felt down or depressed?	Y	N	In the past few weeks have you lost interest in doing things?	Y	N
If you have concerns about your memory do you feel that you should be tested for dementia?	Y	N	Do you struggle to hear conversations	Y	N
			Do you have trouble hearing the TV or radio	Y	N

Do you experience incontinence problems? Y N

Please list all other physicians/care providers and the condition they are treating

FOR OFFICE USE ONLY: ADVANCED CARE PLANNING NEEDED Y N

ADVANCED CARE PLANNING RESOURCES PROVIDED Y N

Revised 1/2018