WELCOME TO AGEWELL MEDICAL ASSOCIATES

We offer the following checklist and suggestions to help make your first visit as easy and pleasant as possible.

What to bring with you:

[ ] **All of your medications in their bottles** (prescription and non-prescription, including vitamins).
[ ] **Health History form** (fill it out ahead of time).
To include:
- List of drug allergies and/or drug sensitivities.
- **2** emergency contact names and phone numbers (1 may be your spouse)

[ ] **Geriatric Depression Screen** (fill it out ahead of time).
[ ] **Copies of your Living Will and/or Durable Power of Attorney for Health Care**, if you have them.
[ ] **Current insurance cards (including prescription drug coverage).** We need to make copies for your chart in order to bill the carriers for your office visits.

What to expect at your Comprehensive Geriatric Assessment Visits: (please allow up to 2 hours for your first time visit.)

- Establish your medical care with your primary care provider
- Limited physical exam
- Review of your current medications
- Review of your medical and surgical history
- Review and discuss your advanced directives (Living Will, Medical Durable POA, etc.)
- Review and discuss preventive care
- Written instructions for changes in treatment plans, lab orders, or diagnostic studies

Please be here 30 minutes prior to your scheduled appointment time.

Your appointment is on _____, the ____of_____ at_____

Your primary care provider will be:_____.If you have any questions, please call us at (719) 475-5065. Our hours are 8:00 AM to 4:30 PM weekdays.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE CALL US AS SOON AS POSSIBLE TO RESCHEDULE. THANK YOU.

FOR OFFICE USE ONLY: MEDICARE OR OTHER
NO AD LW / MDPOA

SENIOR HEALTH HISTORY

NAME: _____
First MI Last

TELEPHONE NUMBER: _____ BIRTHDATE: _____

PHYSICAL ADDRESS:_____
Street City Zip Code

BILLING ADDRESS:_____
(If different from above) Street City Zip Code

E-MAIL:_____ SSN:_____

MARITAL STATUS: Married Single Divorced/Separated Widowed

CURRENT LIVING ARRANGEMENTS (i.e. own home, assisted living, etc):_____

_____

EMERGENCY CONTACT NUMBERS:

Name: _____ Relationship: _____ Phone: _____

Cell:_____

Name: _____ Relationship: _____ Phone: _____

Cell:_____

Medical Power of Attorney: _____ Phone: _____

PHARMACY:_____

DURABLE MEDICAL EQUIPMENT SUPPLIER:_____

Transportation Contact: _____ (2)

AGEWELL MEDICAL ASSOCIATES
SENIOR HEALTH HISTORY

Race:

American Indian or Alaska Native	_____
Asian	_____
Black or African American	_____
Native Hawaiian or Other Pacific Islander	_____
White	_____
Prefer not to give	_____

Ethnicity:

Hispanic or Latino	_____
Not Hispanic or Latino	_____
Prefer not to give	_____

Primary Language: (Choose 1)

English	_____
French	_____
German	_____
Japanese	_____
Mandarin	_____
Russian	_____
Spanish	_____

Name:_____

MEDICAL / SURGICAL/ HOSPITALIZATION HISTORY

HAVE YOU BEEN TOLD THAT YOU HAVE DIABETES OR ELEVATED BLOOD SUGAR?

Y N

If you answered <u>YES</u> to the question above, please answer questions 1 through 4

1. **DATE OF LAST A1C TEST (IF KNOWN):** _____
2. **RESULT OF LAST A1C:** _____
3. **DATE OF LAST DIABETIC EYE EXAM:** _____
4. **WHERE DONE?** _____

DO YOU CHECK YOUR BLOOD SUGARS? Y N How often? _____

MAJOR MEDICAL PROBLEMS:

_____

_____

_____

_____

_____

_____

PAST SURGERIES (INCLUDE DATES/YEAR)

_____

_____

_____

_____

_____

_____

HOSPITALIZATIONS FOR SERIOUS ILLNESS:

_____

_____

_____

_____

_____

_____

Name: _____

NAMES OF OTHER PROVIDERS INVOLVED IN YOUR CARE

NAME	SPECIALTY

HAVE ANY OF YOUR CLOSE RELATIVES HAD ANY HEALTH CHANGES? YES / NO
(PARENTS, SIBLINGS, CHILDREN)

IF YES PLEASE LIST BELOW:

_____

_____

_____

_____

_____

DO YOU OR HAVE YOU EVER USED:

TOBACCO Y/ N

IF YES , THEN HOW MUCH DID YOU USE AND FOR HOW LONG? _____

YEAR QUIT_____

ALCOHOL Y / N

IF YES, HOW MUCH DO YOU DRINK AND HOW OFTEN?

_____

ARE YOU WORRIED ABOUT OR HAVE YOU HAD A RECENT FALL? Y / N

_____

ARE YOU WORRIED ABOUT YOUR MEMORY? Y / N

_____

Name: _____

PLEASE CHECK ANY PREVENTIVE TESTING YOU HAVE HAD DONE

TEST	DATE OF TESTING	FACILITY
MAMMOGRAM		
COLONOSCOPY		
BONE DENSITY		
PAP/PELVIC EXAM		
PROSTATE EXAM		
EYE EXAM		
DENTAL EXAM		
PROSTATE BLOOD TEST		
THYROID BLOOD TEST		
CHOLESTEROL BLOOD TEST		

HAVE YOU HAD ANY IMMUNIZATIONS?

VACCINE	YES / NO	DATE
INFLUENZA (FLU)		
PNEUMOVAX (PNEUMONIA)		
ZOSTAVAX (SHINGLES)		
TETANUS		

DO YOU USE OXYGEN? YES / NO
DO YOU USE CONTINUOUS (24 HOURS)? YES / NO

DO YOU USE AT NIGHT ONLY? YES / NO
BY NASAL TUBING? YES / NO
BY MASK? YES / NO
CPAP / BIPAP (CIRCLE ONE)
WHAT OXYGEN COMPANY DO YOU USE? _____

DO YOU HAVE A LIVING WILL OR ADVANCED DIRECTIVE? YES / NO
(IF YOU HAVE ONE, PLEASE BRING IT TO THE VISIT)

Name: _____ (6)

MEDICATION HISTORY

ARE YOU **ALLERGIC** TO ANY MEDICATIONS AND IF SO PLEASE LIST THEM WITH THE REACTION YOU HAD BELOW

MEDICATION ALLERGY	REACTION

NEW PATIENTS ONLY:

PLEASE BRING ALL YOUR CURRENT PRESCRIPTION MEDICATIONS, OVER THE COUNTER MEDICATION, VITAMINS AND ANY SUPPLEMENTS YOU ARE TAKING.

Name: _____

PHQ-4

Over the last 2 weeks, how often have you been bothered by the following problems?

(Circle answer in each column)

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3

Name: _____ (8)