TEMPUS PRIMARY CARE

ANNUAL MEDICARE WELLNESS PAPERWORK

Name:_____DOB:_____Date:_____

VACCINES: Please specify the most recent date of each vaccine. If you are unsure of the exact date, put an approximate date. If you have not ever received it, put none. For COVID and Shingles vaccines, provide each dose date.

Flu:_____/_____/_____

Tetanus:_____/_____/_____

Shingles: 1.____/_____/_____

2.____/_____/_____

Pneumonia:____/_____/_____

COVID: 1._____/_____/_____ Pfizer, Moderna, or J&J

2._____/_____/_____ Pfizer, Moderna, or J&J

3._____/_____/_____ Pfizer, Moderna, or J&J

** Have you ever been COVID positive? YES or NO

HEALTH MAINTENANCE:
Last Hepatitis C Screening:_____/_____/_____
Last Colonoscopy:_____/_____/_____

MALE:
Last PSA: ____/____/_____ (Prostate cancer screening blood test)

FEMALE:
Last Pap Smear : ____/____/_____ OB/GYN:_____
Last Pelvic Exam: ____/____/_____
Last Mammogram: ____/_____/_____ Imaging Facility:_____
Last Bone Density Scan: ____/_____/_____

DIABETIC PATIENTS:
Last Eye Exam: ____/____/_____Optometrist/Ophthalmologist:_____
Last Foot Exam: ____/____/_____

HISTORY OF SMOKING: YES OR NO

If yes, please check the boxes below if they apply or have been completed*

❑ Current Smoker; #_____ packs per day for #_____ years
❑ Former Smoker; quit #_____ year(s) ago; #____ packs per day for #_____ years
❑ Female/Male (age 55-77): Low Dose CT Screening (asymptomatic, current smoker OR quit <15yrs ago, >30pk yr)
❑ Male (age 65-75): AAA Ultrasound Screening

In the questions below, mark ALL that apply

Diet/Nutrition:

❒ Healthy Diet ❒ High Carb Meals ❒ No / Former Alcohol Use ❒ High Caloric Intake
❒ Alcohol Beverages per week:_____ ❒ High Salt Intake ❒ High Fat, Low Fiber

Fracture Risk:

❒ No History of Fractures ❒ History of Fractures
❒ No Sudden Unexplained Fractures ❒ History of Sudden Unexplained Fractures

Physical Activity:

❒ Good Physical Condition ❒ Poor Physical Condition ❒ Exercising Regularly ❒ Not Exercising Regularly

Depression Screening:

❒ No History of Depression ❒ History of Depression ❒ I Never Feel Sad or Empty
❒ I Feel Sad and/or Tearful at This Time ❒ No Loss of Interest ❒ I Have a Loss of Interest in Activities

Orientation:

❒ No Disorientation ❒ Disorientation to time, date, and/or place

Concentration & Memory:

❒ No Decreased Concentration ❒ Decreased Concentration
❒ No Memory Lapses or Loss ❒ Memory Lapses or Loss

Speech & Motor:

❒ No Speech Difficulties ❒ Speech Difficulties
❒ No Difficulty with Fine Motor Tasks ❒ Difficulty with Fine Motor Tasks

Functional Ability:

❒ No Vision Problems ❒ Loss of Vision: Decreased or Total
❒ No Hearing Loss ❒ Loss of Hearing: One or Both Ears ❒ Wears Hearing Aids/Glasses

Activities of Daily Living:

❒Able to Bathe/Dress Self ❒Unable to Bathe/Dress Without Help ❒Able to Prepare Own Meals

❒Unable to Prepare Own Meals ❒Ables to Manage Medications ❒Unable to Manage Medications

❒Able to Control Bowel/Bladder ❒Loss of Bowel/Bladder Control

Fall Risk Assessment:

❒No Fall in the Past Year ❒Fall(s) in the Past Year:_____ ❒Fear of Falling

Home & Self-Safety:

❒Good Lighting in Home ❒Poor Lighting in Home ❒Working Smoke Detectors

❒No Smoke Detectors in Home ❒No Unsafe Floor Hazards (rugs, clutter)

❒Unsafe Floor Hazards ❒No Driving Problems ❒Concerns Regarding Driving

❒Routinely Wearing Seatbelt ❒Not Routinely Wearing Seatbelt

❒I Have Been to the Hospital in the Last Year

Social History:

Who do you live with:_____ Marital Status:_____

Employment Status:_____ Use of Elicit Drugs:_____

(Working, Retired, Disabled, or Unemployed) *(Current, Former, or Never)*

Pain Assessment:

None Mild (1-4) Moderate (4-5) Severe (>5)

Location of Pain:_____

Controlled with Medications: Yes or No

Please Specify:_____

Current Specialists: *Please list the name and specialty.*

1. _____

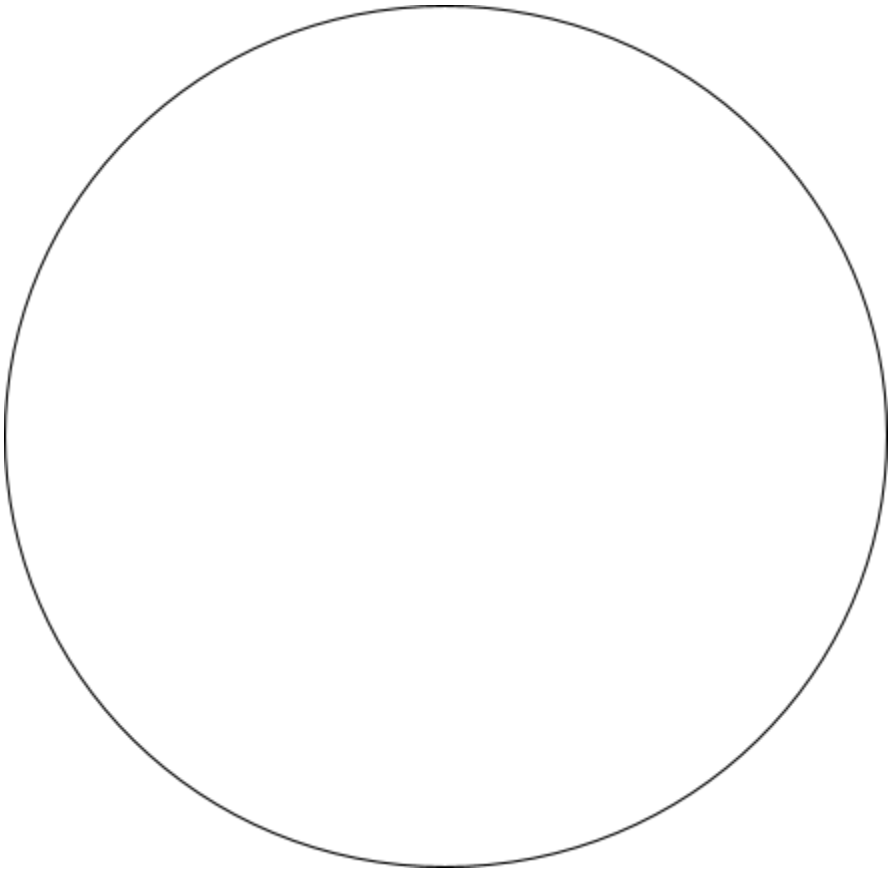
2._____

3._____

Clock Draw Test:

1.Inside the circle, please draw the hours of the clock as they normally appear.

2.Place the hands of the clock to show ***11:10***



Medical Legal Documents: **Please bring a copy of these documents if applicable**

Medical Power of Attorney: Someone to make medical decisions for you in the event you are unable to do so.

Living Will / Advance Directive:Documents that make your healthcare wishes known.

❒I have a Medical Power of Attorney ❒I do NOT have a Medical Power of Attorney

❒I have a Living Will / Advance Directive ❒I do NOT have a Living Will / Advance Directive

Medical Power of Attorney:

Name:_____Relathionship:_____Phone:_____

Name:_____Relathionship:_____Phone:_____

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

0= Not at all 1=Several days 2=More than half the days 3=Nearly every day

1. Little interest or pleasure in doing things.	0 1 2 3
2. Feeling down, depressed, or hopeless.	0 1 2 3
3. Trouble falling or staying asleep, or sleeping too much.	0 1 2 3
4. Feeling tired or having little energy.	0 1 2 3
5. Poor appetite or overeating.	0 1 2 3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0 1 2 3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0 1 2 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0 1 2 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0 1 2 3

Add the score for each column

Total Score (add your column scores): _____

If you checked off any problems above, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very Difficult Extremely Difficult

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

0=Not at all sure 1=Several days 2=Over half the days 3=Nearly every day

1. Feeling nervous, anxious, or on edge.	0 1 2 3
2. Not being able to stop or control worrying.	0 1 2 3
3. Worrying too much about different things.	0 1 2 3
4. Trouble relaxing.	0 1 2 3
5. Being so restless that it's hard to sit still.	0 1 2 3
6. Becoming easily annoyed or irritable.	0 1 2 3
7. Feeling afraid as if something awful might happen.	0 1 2 3

Add the score for each column

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very Difficult Extremely Difficult

FALL RISK ASSESSMENT

Have you fallen in the past year?	NO	YES
Do you use or have you been advised to use a cane or walker to get around safely?	NO	YES
Do you sometimes feel unsteady while walking?		
Do you steady yourself by holding onto furniture when walking at home?	NO	YES
Do you worry about falling?	NO	YES
Do you need to push with your hands to stand up from a chair?	NO	YES
Do you have trouble stepping up onto a curb?	NO	YES
Do you often have to rush to the toilet?	NO	YES
Have you lost some feeling in your feet?	NO	YES
Do you take medicine that makes you light-headed or more tired than usual?	NO	YES
Do you take medicine to help you sleep or improve your mood?	NO	YES
Do you often feel sad or depressed?	NO	YES

WOOHOO YOU FINISHED!!!