UW Medicine
NORTHWEST HOSPITAL & MEDICAL CENTER
AMBULATORY NETWORK

Patient Label

Welcome to Medicare Form

DATE: _____

NAME: Last _____ **First** _____ **MI**_____**GENDER:** _____ **BIRTHDATE:** _____

Please complete the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Please list current members of your healthcare team below:

_____

_____

_____

Allergies:	**Medication or Substance**	**Reaction**
☐ No Allergies		

Current Medications:	**Label – Name**	**Dose**	**Frequency**
OR			
☐ See Attached List			

Review of Nutrition/ Exercise

Do you eat a well-balanced diet, including protein, high fiber, fruits and vegetables? ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No

Type of exercise_____ Frequency_____

Activities of Daily Living

In your present state of health how much difficulty do you have with the following activities? (Please circle one response per statement.)

Preparing food	None	Mild	Moderate	Severe	Complete
Bathing yourself	None	Mild	Moderate	Severe	Complete
Getting dressed	None	Mild	Moderate	Severe	Complete
Using the toilet	None	Mild	Moderate	Severe	Complete
Moving around from place to place	None	Mild	Moderate	Severe	Complete

Activities of Daily Living (Continued)

In the past year have you fallen or had a near fall? ☐ Yes ☐ No
Do you feel safe in your home environment? ☐ Yes ☐ No
Do you find yourself having trouble hearing people speak? ☐ Yes ☐ No
Do you wear a hearing aid/device? ☐ Yes ☐ No
Do you have a fire extinguisher in your home? ☐ Yes ☐ No
Do you have a smoke detector? ☐ Yes ☐ No

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Depression

In the past two weeks, how often have you been bothered by the following? (Please circle one response per statement.)

Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feelings that caused you distress or interfered with your ability to get along socially with family or friends	Not at all	Several days	More than half the days	Nearly every day
Felt stress over health, finances, relationships or work	Not at all	Several days	More than half the days	Nearly every day
Fatigue	Not at all	Several days	More than half the days	Nearly every day
Body pain	Not at all	Several days	More than half the days	Nearly every day

Cardiac Risk Factors — Check all that apply

Smoker	☐ Yes	☐ No	Family History of Heart Disease	☐ Yes	☐ No
Obesity	☐ Yes	☐ No	Sedentary Lifestyle	☐ Yes	☐ No
Diabetic	☐ Yes	☐ No	Hyperlipidemia (High Cholesterol)	☐ Yes	☐ No
Known Heart Disease	☐ Yes	☐ No			

Screening and Preventive Services

Prevnar 13 Vaccine	☐ Yes	☐ No	When	
Pneumovax	☐ Yes	☐ No	When	
Influenza Vaccine	☐ Yes	☐ No	When _____	
Hepatitis B Vaccine	☐ Yes	☐ No	When _____	
Tetanus/Tdap Vaccine	☐ Yes	☐ No	When _____	
Shingles Vaccine	☐ Yes	☐ No	When _____	
Screening EKG	☐ Yes	☐ No	When _____	Abnormal? _____
Cardiovascular Screening Blood Test	☐ Yes	☐ No	When _____	Abnormal? _____
Screening for Diabetes	☐ Yes	☐ No	When _____	Abnormal? _____
Screening for Hepatitis C	☐ Yes	☐ No	When _____	Abnormal? _____
Prostate Serum Antigen (PSA-Men)	☐ Yes	☐ No	When _____	Abnormal? _____
Colorectal Cancer Screening	☐ Yes	☐ No	When _____	Abnormal? _____
Pap Smear and Pelvic Exam (Women)	☐ Yes	☐ No	When _____	Abnormal? _____
Abdominal Aortic Aneurysm Screening	☐ Yes	☐ No	When _____	Abnormal? _____
Mammogram Screening (Women)	☐ Yes	☐ No	When _____	Abnormal? _____
Bone Densitometry Screening	☐ Yes	☐ No	When _____	Abnormal? _____
Screening Lung CT	☐ Yes	☐ No	When _____	Abnormal? _____
Screening Colonoscopy	☐ Yes	☐ No	When _____	Abnormal? _____
Screening for Glaucoma	☐ Yes	☐ No	When _____	Abnormal? _____

Discuss with Provider

Nutrition Counseling	☐ Yes	☐ No
End-of-Life Planning	☐ Yes	☐ No
Living Will	☐ Yes	☐ No
Durable Power of Attorney for Medical Affairs	☐ Yes	☐ No