James A. Gottfried, M.D.
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Tel (419) 668-1101
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MEDICARE ANNUAL WELLNESS VISIT

Name: _____ DOB: _____

Allergies (list medication and reaction) ***(**If more room is needed, please list on the back)***

Medication	Reaction

Tobacco Use? YES ☐ NO ☐

IF YES - What type? (ex: cigarettes, chewing tobacco, pipe, cigar)

IF YES - How long have you used tobacco? _____ How much per day? _____

If you ***USED TO USE*** tobacco, when did you quit? _____

Alcohol Use (How much/how often: _____

Drug use? _____

Medical History: Please circle all medical history/surgery that you have and if not listed please add below list.

MEDICAL HISTORY *(Please circle any that apply)*				
A. Fib	Anemia	Anxiety/Depression	Arthritis	Back Pain
COPD / Emphysema	CANCER: Prostate Breast Skin Colon Cervix		Elevated cholesterol	Diabetes 1 or 2
Heart Attack	Heart Burn	Heart Disease	High Blood pressure	Osteoporosis
Seizures	Stroke	Thyroid disease		
SURGERIES *(Please circle any that apply)*				
Appendix	Bowel surgery	C-section	Gallbladder	Hysterectomy
Heart Bypass/ Heart Stents	Joint surgery:	Hip Knee	Shoulder Foot	Spine surgery

Please add any additional problems / surgeries not listed

above:_____

_____

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Family History: Please Circle those that apply

Alcoholism	Cancer	High Cholesterol	Seizures
Anemia	Diabetes	Hypertension	Stroke
Arthritis	Heart Disease	Obesity	Thyroid Disease
Bleeding Disorder	Liver Disease	Kidney Disease	Tuberculosis

Are you on any special diet ? YES ☐ NO ☐

If yes, why?

_____

_____

_____

✦ **Please bring in all medication you are currently taking include prescription medication, vitamins, and supplements.**

✦ **Please provide a list of all physicians that you are currently seeing and for what conditions. (Example Dr. Ibraham-Cardiologist-heart attack).** *See attached list.*

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The following questions are screening questions to better access how you are doing in various aspects of your daily living. Please answer questions truthfully. The doctor will discuss these answers with you at your annual visit.

1. Over the last two weeks, have you felt down, depressed or hopeless?

YES ☐ NO ☐

2. Over the last two weeks, have you felt little interest or pleasure in doing things?

YES ☐ NO ☐

3. Do you have trouble hearing the television or radio when others do not?

YES ☐ NO ☐

4. Do you have to strain or struggle to hear/understand conversations?

YES ☐ NO ☐

5. Do you need help with preparing meals, transportation, shopping, taking your medicine, managing your finances, or other activities of daily living?

YES ☐ NO ☐

6. Do you live alone?

YES ☐ NO ☐

7. Does your home have throw rugs, poor lighting, or slippery bathtub/shower?

YES ☐ NO ☐

8. Does your home **HAVE** grab bars in bathroom, handrails on stairs and steps?

YES ☐ NO ☐

9. Does your home **HAVE** working smoke alarms?

YES ☐ NO ☐

10. Do you have an advance directive (living will, DNR)?

YES ☐ NO ☐

If ***YES*** to question 10 where is it on file? _____

Do you have any questions about advance directives, and do you wish to discuss with your physician during your annual visit?_____

_____

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Please provide a list of all physicians that you are currently seeing and for what conditions.

(Example Dr. Ibraham-Cardiologist-heart attack)

Specialty	Doctor's Name	Reason for visiting doctor	Location of Doctor
Cardiology	Dr. Ibraham	Heart attack	Fisher Titus hospital