New Providence Internal Medicine Associates

Primary Care Partners
Affiliated with
Atlantic Health System

Thank you for scheduling a routine Medicare **Annual Wellness Visit**. This is a perfect opportunity for us to work together to keep you healthy.

There is a lot of information about you that we need to gather and review. We probably have much of your medical history already, but it is best if you can review and confirm that we are completely up to date. This will let us use the time during our visit most effectively. You can share your information with us in 2 ways:

- Through MyChart (phone app or website). Complete all the information in the "e-check in" section, especially the Wellness Visit portion. This will then go directly to your file in our electronic record.
- Or, answer all the questions on the sheets in this packet (even if you have completed similar forms in the past).

According to Medicare rules, the Wellness Visit does NOT include the diagnosis or treatment of new or ongoing problems. We can diagnose and treat new or ongoing problems at the time of your Wellness Visit, but your insurance may require us to apply a deductible or co-payment for that service. If you would prefer, we would be happy to schedule a separate visit to diagnose and treat additional problems and diagnoses.

We are honored that you have entrusted us with providing your medical care.

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If you are able to, please review your MyChart account, as many questions can be completed on-line.
If you are not able to access MyChart, then please complete the form below. Thank you.

(PREVENTIVE VISIT DOES <u>NOT</u> INCLUDE TREATMENT OF NEW OR ONGOING PROBLEMS)

Your Name	Date of Birth	Provider you are seeing	Date of your exam
		Dr. Zukoff, Dr. Hakim, Samantha Anderson, PA	

Please list all medications, supplements, vitamins, etc. Use additional sheets if needed.

Name of medication	dosage	When do you take it	comments

List names of other doctors you see	

Please complete all sections below:

Ongoing health problems	
Past health Problems	
Past surgeries	
Hospitalizations (not for surgery)	
Allergies to medications	

	Age (or year of birth)	Age when deceased	Health problems and conditions (diabetes, heart attack, stroke, cancer, etc.)
Mother			
Father			
Sibling			
sibling			

Do you drink alcohol? Yes, No	How many drinks per week?

Smoking

Do you currently smoke?	Had you been a smoker in the past?	Age (or year) when started and stopped	How many packs per day

What kind of regular exercise do you do?	
How often and how long do you exercise?	

Marital status	Single, significant other, married, separated, divorced, widowed

Your Name: _____

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Number of children	

Circle appropriate answers below:

In general, how would you say your health is?	Excellent, Very Good, Good, Fair, Poor
How often do you get the social and emotional support you need?	Always, Usually, Sometimes, Rarely, Never
Are you having trouble with your hearing?	Yes, No
Are you having trouble with your vision?	Yes, No
Do you or your family members report that you have difficulty remembering things?	Yes, No
Number of falls in past year:	None, 1, 2 or more
Are you afraid of falling?	Yes, No
How many days per week do you exercise?	1,2, 3 or more
Describe what type of exercise you typically do:	
Nutrition: typical day:	
Servings of fruit	1, 2, 3 or more
Servings of vegetables	1, 2, 3 or more
Servings of high fiber/whole grains	1, 2, 3 or more
Servings of simple carbohydrates	1, 2, 3 or more
Servings of high fat food	
Activities of daily living:	
Are you able to dress yourself	Yes, No
Are you able to bathe yourself	Yes, No
Are you able to manage stairs	Yes, No
Are you able to use the telephone	Yes, No
Are you able to do housework	Yes, No
Are you able to prepare meals by yourself	Yes, No
Are you able to do laundry?	Yes, No
Are you able to manage medications?	Yes, No
Are you able to handle money?	Yes, No
Are you able to shop?	Yes, No
Are you able to travel?	Yes, No
Home Safety:	
Does your home have good lighting near doors, stairs ?	Yes, No
Does your home have clutter free floors and stairs?	Yes, No
Does your home have sturdy handrails on all stairs?	Yes, No
Does your home have grab bars present in bath areas?	Yes, No
Does your home have non slip carpets and throw rugs?	Yes, No
Does your home have working smoke detectors?	Yes, No
Does your home have working carbon monoxide detectors?	Yes, No
Mood: over the past 2 weeks have you experienced:	
Little interested or pleasure in doing things	0=Not at all; 1=Several Days; 2=More than half the days; 3=Nearly every day
Feeling down, depressed or hopeless	0=Not at all; 1=Several Days; 2=More than half the days; 3=Nearly every day
Advanced Directives	

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Do you have a Living Will, Healthcare Power of Attorney, or POLST?	Yes, No

Routine Screening and Vaccines

Please enter the date of the last test/vaccine

Test	Date
Colonoscopy	
Cologuard	
Mammogram	
Pap test	
Bone Density (DEXA) scan	
Eye exam	
Vaccine	
Tetanus (dTAP, Boostrix, Adacel, dT)	
Flu Shot	
Pneumovax	
Prevnar	
Shingles (Shingrix)	
Covid	

Please list any other specific questions or medical issues that you would like to address during today's visit:
(Note that we may not be able to completely assess and treat all issues at today's visit, but we will begin a plan. We can often cover other issues and diagnoses besides the Wellness Visit, but insurance requires us to submit a claim for this, which may result in copayment, deductible, etc.)

Please list refills that you need, or prescriptions for routine testing such as mammogram, bone density, etc.

Your Name: _____