PATIENT HEALTH HISTORY FORM DIRECTIONS AND VISIT DAY INSTRUCTIONS

Prior to your Appointment:

STEP 1: Forms

Please complete all the attached forms and bring them with you on the day of your visit.

STEP 2: Labs

Please have your labs drawn "at least" one week prior to your appointment if you would like to discuss your results at that time of you visit

PLEASE FAST for 12 hours before your labs.

~ **Enclosed** you will find your lab order which can be done prior to your visit.

Note: Labs for Wellness Exam can ONLY be drawn at the
QUEST DIAGNOSTICS 805 Locust Street, Philadelphia, PA, 19107
Hours are: Mon-Fri: 7:00am – 3:30pm
Office is closed for Lunch from 12:00 pm – 1:00 pm
MDVIP Membership Fee includes the cost of the labs.
*****If you take this lab slip to any other lab you WILL be charged an out of pocket fee.***

STEP 3: (optional) MDVIP Patient Portal

~ Available on the MDVIP portal is the *Interactive Health Assessment* that is a tool that will help you identify your health risks.

If you do not have a username & password and would like one, please contact:
MDVIP Corporate at 1-866-696-3847 or online @ connect.mdvip.com/request-registration-key

On the Day of your Appointment:

- Please do not wear any perfumes, lotions or oils, since they may interfere with an ECG tracing.

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Established Patient Forms

Please complete these forms in advance of your appointment and bring them with you. Thank You.

Name:_____ **DOB:**_____

Date:_____

Please complete these forms in advance of your appointment and bring them with you. Thank You.

What **problems** do you wish to discuss with the doctor during your evaluation today?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have an Advance Directive? Yes / No

Please list any **NEW** allergies to medications**:** Drug / Reaction

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Surgical History:

Please list any surgeries from the last year	**Date**

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In the last few weeks have you had problems with any of the following?

Falls:	**( )Yes ( ) No**
Fatigue:	**( )Yes ( ) No**
Chest Pain:	**( )Yes ( ) No**
Sortness of Breath:	**( )Yes ( ) No**
Palpitations:	**( )Yes ( ) No**
Leg Swelling:	**( )Yes ( ) No**
Rash :	**( )Yes ( ) No**
Nasal Congestion:	**( )Yes ( ) No**
Sore Throat:	**( )Yes ( ) No**
Hearing Loss:	**( )Yes ( ) No**
Post Nasal Drip:	**( )Yes ( ) No**
Dizziness:	**( )Yes ( ) No**
Abdominal Pain:	**( )Yes ( ) No**
Nausea:	**( )Yes ( ) No**
Vomiting:	**( )Yes ( ) No**
Heart Burn:	**( )Yes ( ) No**
Indigestion:	**( )Yes ( ) No**
Diarrhea:	**( )Yes ( ) No**
Constipation:	**( )Yes ( ) No**
Change in Bowel Habits:	**( )Yes ( ) No**
Blood in Stool:	**( )Yes ( ) No**
Hemorrhoids:	**( )Yes ( ) No**
Bleeding Problems:	**( )Yes ( ) No**
Clotting Problems:	**( )Yes ( ) No**
Joint Pain:	**( )Yes ( ) No**
Back Pain:	**( )Yes ( ) No**
Headache:	**( )Yes ( ) No**
Tingling/Numbness:	**( )Yes ( ) No**
Sleep Problems:	**( )Yes ( ) No**
Visual Changes:	**( )Yes ( ) No**
Memory Loss:	**( )Yes ( ) No**
Anxiety:	**( )Yes ( ) No**
Sleep Disturbances:	**( )Yes ( ) No**
Urinary Frequency:	**( )Yes ( ) No**
Urinary Urgency:	**( )Yes ( ) No**
Blood in Urine:	**( )Yes ( ) No**
Urinary Incontinence:	**( )Yes ( ) No**
Kidney Stones:	**( )Yes ( ) No**

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MDVIP LONG LIVE HEALTHY

Social History

Please answer the following questions.

What is your Marital Status? () Single () Married () Partnered () Divorced/ Separated () Widowed

How many people in household? () 1 () 2 () 3 () 4 ()5+

Highest education level? () High School () College () Graduate

Do you use recreational drugs? () Yes () No

Are there guns in your home? () Yes () No

Do you have a working smoke detector at home? () Yes () No

Do you exercise? () Never () Occasional () 1-2 Days a week () 3+ Days a week

Any questions about sex that you would like to discuss with the doctor? () Yes () No

Do you have regular eye care? () Yes () No

Do you have regular dental cleanings? () Yes () No

Are you on a special diet? () Yes () No

Have you've been a victim of abuse? () Yes () No

How is life in general? () Disastrous () Fair () Good () Very Good () Excellent

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MDVIP LONG LIVE HEALTHY

Burns Checklist ~ PHQ-9

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

(Use "x" to indicate your answer)

	~ 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				
2) Feeling down, depressed or hopeless				
3) Trouble falling or staying asleep, or sleeping too much				
4) Feeling tired or having little energy				
5) Poor appetite or overeating				
6) Feeling bad about yourself or feeling that you are a failure or that you have let yourself or your family down				
7) Trouble concentrating on things such as reading or watching TV				
8) Moving or speaking so slowly that other people could have noticed or being so fidgety or restless that you have been moving around a lot more than usual				
9) Thoughts that you would be better dead or that you want to hurt yourself in some way				

Beck Index

How much you have been bothered by each symptom in the past week, including today....	~ 0 ~ None Not at all	~ 1 ~ Mildly Didn't bother me much	~ 2 ~ Moderately Unpleasent, but could stand it	~ 3 ~ Severely Could barely stand it
Numbness or tingling				
Feeling hot				
Wobbliness in legs				
Unable to relax				
Fear of the worst happening				
Dizzy or lightheaded				
Heart pounding or racing				
Unsteady				
Terrified				
Nervous				
Feelings of choking				
Hands trembling				
Shaky				
Fear of losing control				
Difficulty breathing				
Fear of dying				
Scared				
Indigestion or discomfort in abdomen				
Faint				
Face flushed				
Sweating (not due to heat)				

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MDVIP LONG LIVE HEALTHY

The CAGE and CAGE-AID Questionnaire

Do you drink alcohol?	◯ Yes	◯ No
Have you ever experimented with drugs?	◯ Yes	◯ No
In the last three months, have you felt you should cut down or stop drinking or using drugs?	◯ Yes	◯ No
In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?	◯ Yes	◯ No
In the last three months, have you felt guilty or bad about how much you drink or use drugs?	◯ Yes	◯ No
In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?	◯ Yes	◯ No

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PATIENT NAME:_____DATE:_____

Medicare Annual Wellness Visit Self-Assessment Form

(For Medicare Patients Only Please)

Please think about how you would answer the following questions based upon how you have been doing in the past four weeks Your answers will help you receive the best possible healthcare and allow us to identify areas in which we can help you best.

FALLS RISK

1	Have you fallen two or more times in the past year?	YES	NO
	If yes were you injured?	YES	NO
2	Do you have difficulty with dizziness or problems with balance?	YES	NO
3	Do you avoid doing things due to the fear of falling?	YES	NO
4	Do you have things in your house which might cause you to fall?	YES	NO

PHYSICAL ACTIVITY AND PAIN

1	How often does physical/emotional health interfere with your daily activities?	Frequently	Occasionally	Almost never
2	How often do you take the escalator over the stairs?	Frequently	Occasionally	Almost Never
3	How often does pain interfere with your normal activities?	Frequently	Occasionally	Almost never
4	How much pain do you have on a daily basis?	0 1 2 3 4 5 6 7 8 9 10		
	If you do have daily pain, where is the pain located? _____			
5	Approximately how many days each week are you physically active?	0-1 days	2-3 days	4 or more
6	How many days a week do you exercise?	0-1 days	2-3 days	4 or more
7	How many hours of sleep do you usually get each night?	5 or less hours	6-7 hours	8 or more hours

ACTIVITIES OF DAILY LIVING

1	Can you eat, bathe, get dressed, get around your home without help?	YES	NO	
2	Are you able to prepare your own meals?	YES	NO	
3	Are you able to do your own housekeeping without help?	YES	NO	
4	Are you able to shop without help?	YES	NO	
5	Can you handle your own money without help?	YES	NO	
6	Are you able to travel independently by bus or taxi?	YES	NO	
7	Do you have enough help at home with your care or doing chores?	YES	NO	
8	Do you drive a car?	YES	NO	
	If yes: do you have any difficulty driving?	None	Some Difficulty	Very Difficult

OTHER HEALTH ISSUES

1	When was your last dilated eye exam? _____		
	Name of your eye doctor:_____		
2	Do you have problems with your hearing?	YES	NO
3	Do you have problems with your memory?	YES	NO
4	Do you have trouble eating well?	YES	NO
5	Do you have trouble with your teeth or dentures?	YES	NO
6	Do you have a Living Will?	YES	NO
	If yes, have you given us a copy?	YES	NO
7	Did you get a flu shot this year?	YES	NO
	If not do you want one?	YES	NO

PLEASE TURN PAGE

PATIENT NAME:_____
DATE:_____

Medicare Annual Wellness Visit Self-Assessment Form
Page 2

BLADDER CONTROL

1	Is leaking of urine a problem for you?	YES	NO	N/A	
2	Has urine leakage changed your activities or interfered with sleep?	YES	NO	N/A	
3	If urine leakage is a problem for you, would you be willing to try:				
	Medications	YES	NO		
	Bladder Training Exercises	YES	NO		
	Surgery	YES	NO		

MEDICATIONS

Remembering to take your medications can sometimes be challenging.

1	How often did you miss taking one or more of your medication in the last 2 weeks?	Almost never	Occasionally	Frequently	
2	Are you unsure/confused about what your medications are for?	YES	NO	N/A	
3	Are you unsure/confused about how or when to take your medications?	YES	NO	N/A	
4	Are you unsure/confused about why you need to take your medications?	YES	NO	N/A	
5	Do you have any medications your cannot afford?	YES	NO	N/A	
6	Do you have trouble getting your medications due to the inability get to the pharmacy or the inability to have them delivered?	YES	NO	N/A	
7	Do you have concerns/questions about your medication's side effects?	YES	NO	N/A	
8	Do you have difficulty taking medicine the way you are instructed?	YES	NO	N/A	

ISSUES EFFECTING YOUR HEALTH

1	In the past year, was there a time when you couldn't afford to see a doctor?	YES	NO		
2	Are you worried at times you cannot get your medicine due to expenses?	YES	NO		
3	Do you ever eat less because there isn't enough food?	YES	NO		
4	Are you worried that in the next few months you may not have housing?	YES	NO		
5	Do you feel your safety is threatened in your home?	YES	NO		
6	In the past year, have you had a hard time paying your utility bills?	YES	NO		
7	Do you feel like it is a hardship to obtain household supplies?	YES	NO		
8	Do you have any problems with access to transportation to get to your medical appointments?	YES	NO		
9	Do you need a translator to communicate with your provider?	YES	NO		
10	Do you have difficulty learning about your medical condition from the information given to you or what is told to you?	YES	NO		
11	Do you miss having people around you?	YES	NO		
12	Do you receive enough support from family and friends?	ALWAYS	USUALLY	SOMETIMES	NEVER
13	How confident are you that you can control and manage most of your health problems?	VERY	SOMEWHAT	NOT VERY	N/A

SATISFACTION WITH ACCESS

1	In the past 12 months, how often did you get an appointment in the amount of time you felt was appropriate?	ALWAYS	USUALLY	SOMETIMES	NEVER
2	In the past 12 months, how satisfied are you with the care or treatment you received in this office?	VERY	SOMEWHAT	NOT VERY	N/A

PLEASE TURN PAGE OVER

Medicare Preventative Services Recommendations Con't

HOME SAFETY

- In all living areas, avoid throw rugs and secure any loose carpet edges with nonskid tape.
- Make sure the floor is devoid of clutter and nightlights or motion-sensitive lighting are maintained throughout the home.
- Adding contrasting color strips to stairs aids in weakened depth perception and implementing grab bars and handrails helps with depreciated balance.
- Emergency numbers should be listed in large print by each phone. It's also smart to consider installing an electronic emergency response system, like Life Alert.

MEDICATION SAFETY

- Know the names of your medicines.
- Complete a Medication List and keep the list updated. Take it with you on each visit to your doctor or pharmacist, and whenever you travel away from home.
- Take your medicines until they're gone. This is especially important for antibiotics. If you are prescribed two weeks' worth of pills, don't stop them in a few days "because you're feeling better." These medicines need to be taken for the total duration of time that they are prescribed to completely clear the infection and keep it from coming back.
- Don't mix pills in bottles with other pills. Keep them in their original container (unless you place them in a dispenser).
- Be alert for any side effects, especially when starting a new medicine or increasing the dose of an existing medicine. Any new symptom in an older adult should be considered a medicine side effect until proved otherwise. Check with your doctor or pharmacist if you have any questions or suspect that your medicine may be causing problems.
- Use one pharmacy for all your prescription medicines. This will reduce the chance that you will obtain conflicting medicines from different pharmacies.
- Ask your pharmacist's advice before splitting or crushing any pills. Some pills should only be swallowed whole and may produce dangerous effects if the pill is altered.
- Keep all medicines out of the reach of children.
- Discard any medicines that you are no longer taking. Having old medicines around the house increases the risk that you or a family member might take them by accident, or that a child might get into them. Keep your medicines securely stored in a safe place.

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Medicare Preventative Services Recommendations

- Mammogram every 1- 2 years for women until age 85
- Glaucoma screening with your optometrist or ophthalmologist every 2 years
- Vision screening as recommended by your eye care provider
- Diabetes screening every year
- Cholesterol screening at least every 5 years
- Colonoscopy screening every 10 years until age 75 or more frequently as recommended
- Influenza vaccine yearly
- Shingles vaccine once after age 60 (This may or may not be covered by Medicare part D depending upon insurance coverage purchased by patient)
- Pneumonia vaccine once after age 65 (This is covered by Medicare)
- Tetanus /pertussis/diphtheria booster once after age 65 and every 10 years (This is NOT paid for by Medicare and is an additional cost to the patient)
- DEXA scan screening for osteoporosis in women after age 65 and in high risk men after age 70
- Stop Smoking
- Decrease Alcohol
- Exercise for 30 minutes or more 3 times a week
- Lose Weight
- Dietary Recommendations:
    - Make one half your plate fruits and vegetables
    - Make at least half your grains whole
    - Choose foods and drinks with little or no added sugars
    - Look out for salt (sodium) in foods you buy
    - Eat fewer foods that are high in saturated fats (animal fat, butter, cream, whole milk, stick margarine, coconut and palm oil
    - Eat the right amount of calories for you (get a personal daily calorie list at www.ChooseMyPlate.gov)
    - Use food labels to help make better food choices

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