ANNUAL HEALTH QUESTIONNAIRE AGE 65 AND OVER

Name _____ Birthdate_____ Date_____

Married ____ Single____ Divorced____ Widow____ Partnered_____

Do you live alone? ✔Yes __No If no, please specify who lives with you _____

Do you have a caregiver? _Yes _No

Do you live in a: ____House ____Apartment ____Senior Living Community ____Skilled Nursing Facility

Did you drive yourself to the office today? ___Yes ___No If no, please specify how you arrived today _____

Have you completed an Advanced Directive? ___Yes ___No

If YES, do we have one on file.___Yes ___No (Please note, Medicare requires your Primary Care Physician to have a copy on file.)

HEALTH MAINTENANCE	
Last Date of Physical Exam Month_____Year_____	Last Date of Tetanus Vaccine Month_____Year_____
Last Date of Colorectal Cancer Screen Month____Year____	Last Date of Flu Vaccine Month_____Year_____
Last Date of Mammogram Month_____Year_____	Last Date of Pneumonia Vaccine Month_____Year_____
Last Date of PAP Smear Month_____Year_____	Last Date of Eye Exam Month_____Year_____

DRUG ALLERGIES

CURRENT MEDICATIONS

FAMILY HISTORY			
Diagnosis	**Father**	**Mother**	**Siblings**
Heart Disease			
High Blood Pressure			
Stroke			
Cancer			
Glaucoma			
Diabetes			
Epilepsy			
Bleeding Disorder			
Kidney Disease			
Thyroid Disease			
Mental Illness			
Osteoporosis			

HOSPITALIZATION OR SURGERY	
Reason: Date:	Reason: Date:

PAST MEDICAL HISTORY

- □ A.D.D.
- □ Allergies/hay fever
- □ Anemia
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Benign prostatic hypertrophy/enlarged prostate
- □ Breast cancer
- □ Breathing problems caused by emphysema or asthma
- □ Bronchitis
- □ Cancer _____ type
- □ Depression
- □ Diabetes Type I_____ Type II_____ Last A1C results ____
- □ Gall bladder disease
- □ Gout
- □ Heart arrhythmia
- □ Heart attack
- □ Heart disease
- □ Heart failure or an enlarged heart
- □ Heart murmur
- □ Hepatitis
- □ High cholesterol
- □ Hypertension/high blood pressure
- □ Incontinence
- □ Kidney disease
- □ Lactose intolerant
- □ Migraines
- □ Osteoporosis
- □ Other GI disorder
- □ Peripheral vascular disease
- □ Pneumonia
- □ Prostate cancer
- □ Sexual dysfunction
- □ Sexually transmitted disease
- □ Sleep apnea
- □ Stomach ulcer
- □ Thyroid disease
- □ Other _____

HABITS	
Smoke: Packs daily _____ How long_____ When stopped_____	Diet: Salt intake _____ Fat intake _____
Coffee: Cups daily _____ Other caffeine_____	Exercise: What_____ Length_____ How often_____
Alcohol: Type_____ Amount_____	Other recreational activities_____

SELF ASSESSMENT QUESTIONNAIRE

Have you experienced any recent weight change? ____Weight gain ____Weight loss ____No change

Question	Always	Sometimes	Never
Do you wear dentures?			
Do you have any problems hearing?			
Do you wear hearing aid(s)?			
Do you have problems with vision?			
Do you wear contacts/glasses?			
Do you have pain?			
If yes, where_____ ; rate on a scale of 1-10 (least-most severe)_____			
Are you able to do your own grocery shopping?			
Are you able to prepare your own meals?			
Are you able to groom yourself daily?			
Are you able to use the restroom by yourself?			
Do you have any difficulty ambulating?			
Do you think you are at high risk of falling?			
Do you have any problems/concerns with your memory?			
Are you able to recall recent events?			
Are you able to recall past events?			
Do you ever feel confused or lost?			
Have you or others noticed inappropriate behavior in your actions?			
Do you have any recent major stress in your life?			
Do you feel down or depressed?			
Do you have any difficulty sleeping?			
Do you think you are at risk of admission to a hospital?			
Do you think you should be living at a skilled nursing facility?			
Can you organize and take your medication by yourself?			
Please indicate the number of over the counter medication being taken each day or answer 0 for None _____			

SELF PLAN AND FUTURE GOALS

Sleep Disorder Questionnaire

Patient Name: _____ Height: _____

Email: _____ Weight: _____

Gender: M F BMI: _____ DOB: _____ Neck Size: _____

Please circle answer:

Do you snore:	None	Soft	Moderate	Loud	Disruptive

Snoring can be heard outside of the bedroom	Yes	No
Snoring is present only when sleeping on back?	Yes	No
Do you have unexplained awakenings from sleep?	Yes	No
Do you awaken from sleep gasping for air or choking?	Yes	No
Do you notice frequent twitching or jerking of legs while asleep?	Yes	No
Do you lack energy upon waking in the morning?	Yes	No
Do you have a headache upon waking in the morning?	Yes	No
Do you often lay in bed unable to fall asleep?	Yes	No
Do you wake up during the night and are unable to fall back asleep?	Yes	No
Do you find it difficult to stay awake during the day?	Yes	No

*****If you have answered YES to any one of the above questions please consult with your doctor*****

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Please answer with a 0 to 3

0 = Would never doze 1 = Slight chance of dozing

2 = Moderate chance of dozing 3 = High chance of dozing

Sitting and reading	_____
Watching T.V.	_____
Sitting inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Score	_____

*****If your Epworth score is 10 or greater please consult with your doctor*****

Physician Name: _____

Phone: _____ Fax: _____

Sleep Questionnaire Provided By REM Sleep Labs (888) 866-1211

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SouthCoast MEDICAL GROUP
Family Care + Urgent Care
Sports Care

Understanding Preventative Screening
Please Read and Sign

Dear Patient,

This waiver is intended to ensure that you, our valued patient, understand what will be addressed during your annual preventative appointment.

A routine Annual Preventative exam is a preventative focused screening. It is not problem focused visit.

Your scheduled appointment today is only to address your annual wellness exam.

At your preventative exam, the healthcare provider will review:

- Past medical, social and family history
- Update your charts medication list to ensure it is up to date
- Routine vaccinations that might be due
- Age and gender appropriate screening tests (i.e. annual routine bloodwork, blood pressure screening, pap smear, mammogram, colonoscopy).
- **If your results are within normal limits, we will send you your results via the pt. portal. If your screenings are not within normal limits, our staff will call you and get you on the schedule ASAP for a follow up visit with your medical provider so that you fully comprehend your results, review your treatment plan and are in agreement with the treatment plan given.**

Services that are not covered during a preventative exam include:

- New or recurring health problems and/or injuries
- Medication changes/adjustments and refills
- Problem specific referrals to specialists

By signing below, I _____ acknowledge that I have read
PRINT Patient's Name
the above information and understand that I am scheduled for my routine annual preventative exam and that I have not been scheduled for a problem visit.

_____ _____
Patient signature Today's Date

Understanding your preventive care benefits

Seeing your doctor once a year for a preventive care visit (also known as an annual routine checkup) can help catch small problems before they turn into big, costly ones.

Even if you're feeling fine, scheduling an appointment with your doctor for preventive care services is important. Through a preventive exam and routine health screenings, your doctor can determine your current health status and detect early warning signs of more serious problems.

What's covered in a preventive care visit

The University of California Medicare and non-Medicare plans cover 100% of the costs for preventive health services when care is provided through network providers. (UC Care members can access preventive care through UC Select and Blue Shield Preferred providers.)

During your visit, your doctor will determine what tests or health screenings are right for you based on factors such as your age, gender, health status, and health and family history.

Examples of covered services include:

- Physical exams
- Immunizations
- Select screenings

What's not covered

If you discuss medical concerns or current illnesses, the entire visit may be considered a medical treatment visit and would not be covered as preventive care. You will be required to pay the plan's physician office copayment or coinsurance.

Preventive or not?

Here's a list of some common services that may or may not be covered during a preventive care visit. For a full list of covered services, including recommended screenings and tests by age and gender, visit **blueshieldca.com/preventive.**

Type of service	Services covered under preventive care	Services considered medical treatment requiring payment
 **Physical exam** This exam is prevention focused, not problem focused.	Routine physical exams where your doctor reviews the following: • Past medical, social, and family history • Medications • Age-/gender-appropriate screening tests	• New health problems discussed with your doctor during your visit • Diagnoses that need to be addressed such as high blood pressure, diabetes, skin rash, and headaches
 **Immunizations** Your doctor will advise on recommended immunizations that can protect against a number of serious diseases.	• Flu vaccination • Hepatitis A & B • MMR (measles, mumps, rubella)	Many travel vaccines are not covered including: • Typhoid • Malaria • Rabies
 **Screenings** Your doctor will determine what tests or health screenings are needed based on your age, gender, and overall health status	• Breast cancer mammography screenings for women over age 40 • Colorectal cancer screening for adults over age 50 • Blood pressure screening for all adults • Cholesterol screening for adults of certain ages or at higher risk	• If abnormalities are found, and additional testing and follow-up procedures are needed during mammography or colorectal cancer screenings • Request for a vitamin D level check to test for bone and muscle development and function • Request for a vaccination filter test to measure the antibodies in your bloodstream to determine if you have an acceptable amount of a vaccination