TANGLEWOOD
FAMILY MEDICAL CENTER

Medicare Health Update

Annual Health Update Questionnaire

Instructions: Please complete this form to the best of your ability and return it to the clinic prior to the day of your Medicare annual appointment.

HEALTH HISTORY QUESTIONNAIRE

NAME (Last, First, M.I.):		**Male** ☐ **Female** ☐ **Other** ☐	**DOB**:	**DATE**:

PERSONAL HEALTH HISTORY

MEDICATIONS: List your prescriptions including OTC drugs such as vitamins and inhalers ☐ **No medications taken**

Name of Drug	Strength	Form	Frequency
(Example): Tylenol	500mg	tablet	1 tab every morning and evening

ALLERGIES: Include antibiotics, narcotics, anesthetics, Iodine, IV, dye, latex, insect bites, pollen, food	☐ **No known allergies**

Allergy	**Reaction**
(Example): *Amoxicillin*	*Skin rash, Hives, etc*

Names/Types of Specialists currently seen:	

Hospitalizations in the last year? Reason?	Date:	Location:

Surgeries/Procedures			**☐ No Surgeries/Procedures**	
☐ Appendectomy (Appendix)	Hysterectomy ☐ Partial ☐ Total	☐ Coronary Stent	☐ Vasectomy	☐ Knee Procedure
☐ Tonsillectomy	☐ Cesarean Section	☐ Coronary Bypass	☐ Prostate Procedure	☐ Hip Procedure
☐ Gall Bladder (Cholecystectomy)	☐ Tubal Ligation	☐ Heart Valve Surgery	☐ Colon Procedure	☐ Back Procedure
☐ Hernia Repair	☐ Breast Procedure/Surgery	☐ Cardiac Pacemaker	☐ Eye Procedure	☐ Sinus Procedure
☐ Other Surgeries:				

MEDICAL HISTORY UPDATE: Check all that apply, write in others	☐ **No health problems**
Cardiovascular	☐ High Blood Pressure ☐ High Cholesterol ☐ Angina ☐ Heart Attack ☐ Irregular Rhythm ☐ Congestive Heart Failure ☐ Heart Valve Problem ☐ Rheumatic Heart Disease ☐ Stroke ☐ Varicose Veins ☐ Rheumatic Fever ☐ Valvular Heart Disease ☐ Mitral Valve Prolapse ☐ TIA
Endocrine	☐ Diabetes (year of onset:_____) ☐ Thyroid Disorder ☐ Adrenal Gland Disease
Pulmonary	☐ Asthma ☐ COPD ☐ Emphysema ☐ Pneumonia ☐ Sleep Apnea ☐ Tuberculosis ☐ Valley Fever ☐ Chronic Bronchitis
Musculoskeletal	☐ Arthritis ☐ Chronic Back Pain ☐ Fractures/dislocations ☐ Osteoporosis ☐ Spasms ☐ Restless Leg Syndrome
Gastrointestinal/ Esophageal	☐ Diverticular Disease ☐ Esophageal Reflux (GERD) ☐ Hepatitis A/B/C ☐ Hemorrhoids ☐ IBS ☐ IBD ☐ Liver Problem ☐ Pancreas Problem ☐ Ulcer ☐ Bleeding
Renal	☐ Kidney Stones ☐ Renal Failure ☐ Recurrent Urinary Tract Infections
Hematological	☐ Anemia ☐ Blood Clots ☐ Blood Transfusion ☐ HIV Positive ☐ AIDS
Infectious	☐ Sexually Transmitted Infection ☐ MRSA ☐ Lyme
Neurological	☐ Migraine Headache ☐ Peripheral Neuropathy ☐ Seizures/Epilepsy ☐ Fainting Spells ☐ Parkinson's Disease ☐ Memory Disturbances ☐ Carpel Tunnel Syndrome ☐ Tremors
Ocular	☐ Diabetic Eye Disease ☐ Cataracts ☐ Glaucoma ☐ Color Blind ☐ Glasses/Contacts ☐ Lasik Surgery ☐ Diabetic Retinopathy ☐ Macular Degeneration
Psychiatric	☐ Depression ☐ Anxiety ☐ Bipolar Disorder ☐ Eating Disorder ☐ Obsessive Compulsive Disorder ☐ Adjustment Reactions ☐ Other:
Cancer	List Type(s):

SOCIAL HISTORY AND HABITS

Tobacco	**Smoking Status:** ☐ Never Smoker ☐ Former Smoker ☐ Secondhand smoke exposure: high ☐ Secondhand smoke exposure: low ☐ Current every day Smoker ☐ Current some day Smoker ☐ Heavy tobacco Smoker ☐ Unknown tobacco status _____Number of years smoking	**Tobacco Type** ☐ Cigarettes ☐ Cigars ☐ Oral ☐ Pipe ☐ Other:	**Describe your daily tobacco use** _____# packs _____# cigarettes _____# chew	**Previous Quit Attempts** ☐ None ☐ Counseling ☐ Hypnosis ☐ Medications ☐ Nicotine replacement ☐ Other:
Caffeine	None	Coffee	Tea	Other	Amount per day?
Alcohol	Do you drink alcohol? ☐ Yes ☐ No		If yes, what type/amount per week?		
Drugs	Do you use recreational drugs? ☐ Yes ☐ No		Type:		Amount:
Sexuality	☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender ☐ Questioning				
Marital Status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Employment/School	Occupation?		Place of employment/school?		

FOR WOMEN
☐ Vaginal Discharge ☐ Vaginal Dryness or Irritation ☐ Change in Libido (sexual interest)
☐ Early loss of ovarian function ☐ Hyperthyroidism ☐ Chronic diarrhea or intestinal malabsorption syndrome
☐ # of Pregnancies (total)_____ ☐ # of Miscarriages_____ ☐ # of Abortions _____
☐ Have had an eating disorder such as anorexia or bulimia ☐ Low calcium intake ☐ Little or no exposure to sun
☐ High caffeine intake (2-3 cups/day)
☐ History of inflammatory bowel disease ☐ Obesity ☐ History of colorectal cancer or polyps
☐ Heavy alcohol use ☐ Inactive lifestyle

FOR MEN
□ Changes in Urinary Stream □ Changes in Libido (sexual interest)
Any issues concerning… (check all that apply):
□ Premature Ejaculation
□ Erectile Dysfunction
□ Sexual Activity, or Fulfillment with Regard to Self or Partner
If yes, please explain: _____

IMMUNIZATIONS

Please indicate with an X whether you've had the following immunizations, and the date of your most recent vaccination.

Name of Immunization	Yes?	No?	Date
Influenza			
Pneumococcal PPSV23 (Pneumovax)			
Pneumococcal PCV13 (Prevnar)			
Hepatitis A series			
Hepatitis B series			
Tetanus booster (dT)			
Tetanus & pertussis booster (Tdap)			
Measles, Mumps, Rubella (MMR)			
Shingles (Zostavax)			
Diphtheria, Tetanus, & Acellular Pertussis			
Rotavirus (RV)			
Inactivated poliovirus			
Human Papillomavirus (HPV) *males and females*			
Meningococcal B			
Other:			
Other:			
Other:			
Other:			

ASSESSMENT OF RISK FACTORS: VISION, HEARING AND ORAL HEALTH: Please check Yes or No and elaborate as needed.

Date of most recent Eye Exam:_____Date of most recent Dental Exam: _____

Yes No

- ☐ ☐ If you are 65 yrs. or older, do you see an eye doctor for regular annual eye exams?
  (If younger than 65, please leave blank)
- ☐ ☐ Do you have a history of glaucoma?
- ☐ ☐ Do you have a family history of glaucoma?
- ☐ ☐ Do you have a history of diabetes mellitus?
- ☐ ☐ Do you wear glasses or contact lenses?
- ☐ ☐ Do you see a dentist at least annually?
- ☐ ☐ Do you brush your teeth daily with toothpaste?
- ☐ ☐ Do you use dental floss?

ASSESSMENT OF RISK FACTORS: WOMEN'S HEALTH: Please check Yes or No and elaborate as needed. If male, please leave blank.

Yes No

- ☐ ☐ Have you had a Pap smear within the past 3 years?
- ☐ ☐ Are you currently or have you ever been sexually active?
  If yes, onset age of sexual activity? _____
  If yes, number of lifetime partners? _____
- ☐ ☐ Have you ever had an abnormal Pap smear?
  If yes, date of abnormal Pap smear___/___/___
  What treatment(s) did you receive, if any? _____
- ☐ ☐ If you are 40 yrs. or older, have you had a mammogram within the past 1-2 yrs? (If younger, please leave blank)

ALCOHOL CONSUMPTION: Please check Yes or No and elaborate as needed.

Yes No

- ☐ ☐ In the past month, did you get drunk or very high on beer, wine or other alcohol?
- ☐ ☐ In the past month, did any of your close friends get drunk or very high on beer, wine or other alcohol?
- ☐ ☐ Have you ever been criticized or gotten into trouble because of drinking?
- ☐ ☐ In the past year, have you used alcohol and then driven a car/truck/van or motorcycle?
- ☐ ☐ In the past year, have you been in a vehicle when the driver has been drinking alcohol or using drugs?
- ☐ ☐ Does anyone in your family drink or take drugs so much that it worries you?

FAMILY HEALTH HISTORY

To the best of your knowledge, Do you have a parent, sibling, child with the following? Please select the family member(s). ☐ **Unknown** ☐ **Adopted**

	Father	Mother	Other- how related?		Father	Mother	Other- how related?
Cancer: Ovarian/Uterine				Osteoporosis			
Cancer: Breast				High Blood Pressure			
Cancer: Prostate				Elevated Cholesterol/Lipids			
Cancer: Colon				Multiple Sclerosis			
Cancer: Other type?				Ulcers/Stomach Disorders			
Diabetes				Bowel Polyps			
Heart Disease				Anxiety			
Hypertension				Mental Illness			
Brain Aneurysms (cerebral)				Depression			
Abdominal Aneurysms (Aortic)				Manic Depression			
Allergies/Asthma				Glaucoma			
Hearing Loss				Alzheimer's/Memory Loss			
Thyroid Disease				Obesity			
Stroke				Parkinson's			
Migraine Headaches				Other:			