

WELCOME TO AGEWELL MEDICAL ASSOCIATES

We offer the following checklist and suggestions to help make your first visit as easy and pleasant as possible.

What to bring with you:

- [] **All of your medications in their bottles** (prescription and non-prescription, including vitamins).
- [] **Health History form** (fill it out ahead of time).
To include:
 - List of drug allergies and/or drug sensitivities.
 - 2 emergency contact names and phone numbers (1 may be your spouse)
- [] **Geriatric Depression Screen** (fill it out ahead of time).
- [] **Copies of your Living Will and/or Durable Power of Attorney for Health Care**, if you have them.
- [] **Current insurance cards (including prescription drug coverage)**. We need to make copies for your chart in order to bill the carriers for your office visits.

What to expect at your Comprehensive Geriatric Assessment Visits: (please allow up to 2 hours for your first time visit.)

- Establish your medical care with your primary care provider
- Limited physical exam
- Review of your current medications
- Review of your medical and surgical history
- Review and discuss your advanced directives (Living Will, Medical Durable POA, etc.)
- Review and discuss preventive care
- Written instructions for changes in treatment plans, lab orders, or diagnostic studies

Please be here 30 minutes prior to your scheduled appointment time.

Your appointment is on _____, the ____ of _____ at _____

Your primary care provider will be: _____. If you have any questions, please call us at (719) 475-5065. Our hours are 8:00 AM to 4:30 PM weekdays.

IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE CALL US AS SOON AS POSSIBLE TO RESCHEDULE. THANK YOU. (1)

**AGEWELL MEDICAL ASSOCIATES
SENIOR HEALTH HISTORY**

Race:

- American Indian or Alaska Native _____
- Asian _____
- Black or African American _____
- Native Hawaiian or
Other Pacific Islander _____
- White _____
- Prefer not to give _____

Ethnicity:

- Hispanic or Latino _____
- Not Hispanic or Latino _____
- Prefer not to give _____

Primary Language: (Choose 1)

- English _____
- French _____
- German _____
- Japanese _____
- Mandarin _____
- Russian _____
- Spanish _____

Name: _____

MEDICAL / SURGICAL/ HOSPITALIZATION HISTORY

HAVE YOU BEEN TOLD THAT YOU HAVE DIABETES OR ELEVATED BLOOD SUGAR?

Y N

If you answered YES to the question above, please answer questions 1 through 4

- 1. DATE OF LAST A1C TEST (IF KNOWN): _____**
- 2. RESULT OF LAST A1C: _____**
- 3. DATE OF LAST DIABETIC EYE EXAM: _____**
- 4. WHERE DONE? _____**

DO YOU CHECK YOUR BLOOD SUGARS? Y N How often? _____

MAJOR MEDICAL PROBLEMS:

PAST SURGERIES (INCLUDE DATES/YEAR)

HOSPITALIZATIONS FOR SERIOUS ILLNESS:

Name: _____

NAMES OF OTHER PROVIDERS INVOLVED IN YOUR CARE

NAME	SPECIALTY

HAVE ANY OF YOUR CLOSE RELATIVES HAD ANY HEALTH CHANGES? YES / NO
(PARENTS, SIBLINGS, CHILDREN)

IF YES PLEASE LIST BELOW:

DO YOU OR HAVE YOU EVER USED:

TOBACCO Y/ N

IF YES , THEN HOW MUCH DID YOU USE AND FOR HOW LONG? _____
YEAR QUIT _____

ALCOHOL Y / N

IF YES, HOW MUCH DO YOU DRINK AND HOW OFTEN?

ARE YOU WORRIED ABOUT OR HAVE YOU HAD A RECENT FALL? Y / N

ARE YOU WORRIED ABOUT YOUR MEMORY? Y / N

Name: _____

PLEASE CHECK ANY PREVENTIVE TESTING YOU HAVE HAD DONE

TEST	DATE OF TESTING	FACILITY
MAMMOGRAM		
COLONOSCOPY		
BONE DENSITY		
PAP/PELVIC EXAM		
PROSTATE EXAM		
EYE EXAM		
DENTAL EXAM		
PROSTATE BLOOD TEST		
THYROID BLOOD TEST		
CHOLESTEROL BLOOD TEST		

HAVE YOU HAD ANY IMMUNIZATIONS?

VACCINE	YES / NO	DATE
INFLUENZA (FLU)		
PNEUMOVAX (PNEUMONIA)		
ZOSTAVAX (SHINGLES)		
TETANUS		

DO YOU USE OXYGEN? YES / NO
DO YOU USE CONTINUOUS (24 HOURS)? YES / NO

DO YOU USE AT NIGHT ONLY? YES / NO
BY NASAL TUBING? YES / NO
BY MASK? YES / NO
 CPAP / BIPAP (CIRCLE ONE)

WHAT OXYGEN COMPANY DO YOU USE? _____

DO YOU HAVE A LIVING WILL OR ADVANCED DIRECTIVE? YES / NO
 (IF YOU HAVE ONE, PLEASE BRING IT TO THE VISIT)

Name: _____

MEDICATION HISTORY

ARE YOU **ALLERGIC** TO ANY MEDICATIONS AND IF SO PLEASE LIST THEM WITH THE REACTION YOU HAD BELOW

MEDICATION ALLERGY	REACTION

NEW PATIENTS ONLY:

PLEASE BRING ALL YOUR CURRENT PRESCRIPTION MEDICATIONS, OVER THE COUNTER MEDICATION, VITAMINS AND ANY SUPPLEMENTS YOU ARE TAKING.

Name: _____

New Patient Depression / Anxiety Screen

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

	Not at All	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Severity Score:				
10. If you checked off any problems, how difficult have these problems made it for you to do your of things at home, or get along with other people	<input type="radio"/> Not difficult at all	<input type="radio"/> Very difficult		
	<input type="radio"/> Somewhat difficult	<input type="radio"/> Extremely difficult work, take care		
11. Feeling nervous, anxious or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Not being able to stop or control worrying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

