# WELCOME TO MEDICARE

**Patient Name:** _____ **Date:** _____
**Age:** _____ **Sex:** ____ **Marital Status:** _____ **Occupation:** _____
**Tobacco Use:** _____**Alcohol Use (amount per week):** _____

## FAMILY HISTORY:

| | Current Health Problems | Cause of Death |
|---|---|---|
| **Mother** | | |
| **Father** | | |
| **Brothers** | | |
| **Sisters** | | |
| **Sons** | | |
| **Daughters** | | |

## PAST MEDICAL HISTORY

**Surgery (list all surgeries you have had)**

**Medical (list all hospitalizations and chronic illnesses)**

**Are you on any medications, vitamins or alternative medications? Yes ____ No____**
**If Yes list medications below:**

**Do you have any allergies or reactions to any medications? Yes____ No____**
**If Yes list medications below:**

**Office Use Only:**
**PATIENT LABEL**

Billings Clinic

## IMMUNIZATIONS

**Please check the immunizations you have received. Include the year if known:**

Office Use Only--FILE IN MISCELLANEOUS

30127443

# WELCOME TO MEDICARE

**Pneumonia _____Influenza _____Tetanus/Diptheria _____**

**Other_____**

## REVIEW OF BODY SYMPTOMS

**Please circle *Yes* if you have had problems with any body areas listed in the past month.**
**Please circle *No* if you have not had any problems with any body areas in the past month.**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Eyes:** | **Yes** | **No** | **Skin:** | **Yes** | **No** | **Genitals** | **Yes** | **No** |
| **Ears:** | **Yes** | **No** | **Lungs:** | **Yes** | **No** | **Joints:** | **Yes** | **No** |
| **Nose:** | **Yes** | **No** | **Heart:** | **Yes** | **No** | **Muscles:** | **Yes** | **No** |
| **Throat** | **Yes** | **No** | **Stomach:** | **Yes** | **No** | **Back:** | **Yes** | **No** |
| **Mouth:** | **Yes** | **No** | **Urinary:** | **Yes** | **No** | **Memory:** | **Yes** | **No** |
| **Neck** | **Yes** | **No** | **Bowels:** | **Yes** | **No** | **Depression:** | **Yes** | **No** |

## REVIEW OF FUNCTIONAL ABILITIES

**Please circle *Yes or No* regarding any of the activities listed below.**

| | | |
|---|---|---|
| **Are you able to do activities like fast walking or bicycling?** | **Yes** | **No** |
| **Are you able to do heavy work around the house like washing windows, walls, or floors?** | **Yes** | **No** |
| **Are you able to go shopping for groceries or clothes?** | **Yes** | **No** |
| **Are you able to get to places out of walking distance?** | **Yes** | **No** |
| **Are you able to bathe either a sponge bath, tub bath, or shower?** | **Yes** | **No** |
| **Are you able to dress, like putting on a shirt, buttoning and zipping, or putting on shoes?** | **Yes** | **No** |

**Above have been reviewed and corrected: _____**
**Physician signature & date**

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