Middletown Valley Family Medicine

MEDICARE VISIT- PATIENT INTAKE FORM

Patient Name	Date of Birth	Sex
Medicare B Eligibility Date	Date of Last Exam	Year of Menopause *(if applicable)*

Social History
Tobacco ☐ Current ☐ 2nd Hand Type:_____ Frequency:_____ Quit Date:_____ ☐ Never ☐ Prior Use
Alcohol ☐ Never ☐ Occasional History of use (describe): ☐ Daily
Caffeine ☐ Never ☐ Occasional ☐ Daily
Drug/ Opioid Abuse ☐ Never ☐ Occasional History of drug/opioid abuse (describe): ☐ Daily ☐ Prior Use Quit Date:_____
Occupation:
Exercise type/frequency:
Home Environment ☐ Private Home ☐ Assisted Living ☐ Other (describe):

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Medicare Visit- Patient Intake Form, Page 2 of 5

Patient Name: _____ Date of Birth: _____

***Family History*- Place a check mark in the box to indicate a positive history**

Medical Condition	**Self**	**Father**	**Mother**	**Brother (Full)**	**Sister (Full)**	**Son**	**Daughter**	**Aunt**	**Uncle**
Alzheimer's									
Alcoholism									
Asthma									
Bleeding Disorder									
Bypass Surgery ***(Indicate age at onset)***									
Cancer ***(Specify Type)***									
Cirrhosis									
Depression									
Diabetes Type 1									
Diabetes Type 2									
Heart Attack ***(Indicate age at onset)***									
Heart Disease (i.e. stent placement, sudden death)									
Hepatitis ***(Specify Type)***									
Hyperlipidemia (i.e. High Cholesterol)									
Hypertension (i.e. High Blood Pressure)									
Inflammatory Bowel Disease (i.e. Crohn's or Ulcerative Colitis)									
Kidney Disease									
Lupus									
Mental Illness									
Migraine									
Multiple Sclerosis									
Osteoporosis									
Psoriasis									
Rheumatoid Arthritis									
Seizures									
Stroke (CVA)									
Thyroid Disease									
Other									

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Patient Name: _____ Date of Birth: _____

Hospitalization History	
Dates of admission in the past year	**Reason for admission**

Allergy List	
Allergies	**Type of reaction**

Medication List	
Prescriptions, Herbals, OTC Drugs	**Dose, Frequency, Route**

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Patient Name: _____ Date of Birth: _____

Problem List	
Active/Chronic Problems	**Specialist/Consultant *(if applicable)***

Past Medical History		
Past Problems	**Approximate Date**	**Specialist *(if applicable)***

Past Surgical History		
Type of Surgery	**Approximate Date**	**Surgeon**

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Patient Name: _____ Date of Birth: _____

Depression Screening		
1. Over the past 2 weeks, have you felt down, depressed, or hopeless?	☐ YES	☐ NO
2. Over the past 2 weeks, have you felt little interest or pleasure in doing things?	☐ YES	☐ NO

Functional Ability/ Safety Screening		
1. Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications, or managing money?	☐ YES	☐ NO
2. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting?	☐ YES	☐ NO
3. Have you noticed any hearing difficulties?	☐ YES	☐ NO

_____ _____

Print Name of Person Completing Form | Relationship to Patient (Note if self)

_____ _____

Signature of Person Completing Form | Date

For Middletown Valley Family Medicine Use Only: The contents of this form have been reviewed at the Medicare Visit appointment.

Comments:

_____

_____

_____

_____ _____ _____

Provider Printed Name | Provider Signature | Date