TODAY'S DATE:	
IODAI JUAIL.	

## ${\bf JOSE\;M\;BAEZ,\,MD,\,LLC}$

Patient name	atient name Date of birth								Age Gender								
Date of Last Welln	rate of Last Wellness (Medicare B eligibility date) Race								Primary Language Spoken								
BP	HR		RR		HT		BMI				WEIGH	T	TEMP				
	•			•		S	OCIAL	. HI	ISTOR	Υ							
<b>707.1660</b> 3	Never	Current	smoker		No. yed	ars smol	ked?	F	Packs pe	er day		Year Qu	it	Other	tobacco		
TOBACCO?	TOBACCO?																
ALCOHOL? Few times/year 1-2 per day				day	3 (	or m	nore per	day		F	ast histo	ry of abı	useYear qu	it:			
ALCOHOL:																	
CAFFIENE?	Never	Occasio	nal		Daily		DIE	ET:									
DESCRIBE ANY H	IISTORY O	F DRUG US	E OR AB	USE	EXE	RCISE RO	OUTINE										
Marital Status ( Cir	rcle one )				Nur	mber of p	pregnan	ncies	5:			Number	of childre	n			
S	М	W D												Liv	ing	Dece	ased
		_			Sex	ual partr	ner pref	eren	nce: N	∕l F							
Highest level of education completed						If retired, what type of work did you do?											
		Private ho	nme	Assista	ed Livin	ng	Nursin	og Ho	ome		Other						
HOME ENVIRONMENT Private home Assisted Living						'6	14415111		onic		Other						
FUNCTIONAL / SAFETY SCREEN (65 AND OVER)																	
Do you need so	omeone (	else to dri	ve for y	ou?			Yes		No	Do y	ou ha	ve any d	ifficulty	feedir	ng	Yes	No
											rself?						
Do have difficu	•	•		g out o	of bed	,	Yes		No	Do y	ou ha	ve diffici	ulty get	ting dr	essed?	Yes	No
walking, or get				ambir	a hai		Yes		No	Dov	,,,,,,,,	od bolo	with wo	ur cho	nning?	Yes	No
shaving, brush		_	mig; (	ומוויטג	ıg IIdl	١,	163		140	) DO 9	ou ne	ed help	vvitii yo	ui 5110	hhiilRt	163	100
Do you need help with housekeeping?						Yes		No	Do y	ou ne	ed help	managi	ng you	ır money?	Yes	No	
			<del>-</del>									· 					
Do you need h	elp mana	aging your	medica	ations?	,		Yes	Ī	No	Do y	ou ne	ed help	using th	e tele	phone?	Yes	No
Daniel :	alue!:		- الداد	. h !	!!-		Voc		No	<u> </u>	1	··· -litte	.14 ***	h le - !	3	Voc	No
poor lighting?	Do you have stairs in your home without handrails or with Yes No Do you have difficulty with balance? Yes						No										
					Yes	No											
Have you noticed any hearing difficulties?  Yes  No  Does your bladder sometimes leak?																	
Do you have a	Do you have a living will or advanced directive?  Yes  No  Have you had days where you felt very little pleasure in									•							
												s <mark>during t</mark> elt down,	•			I Yes	I No I No
Do you have re	gular or	frequent i	pain?	None	Mile	d	Moder	rate	or occas		. you 16	Lit dOWII,	uchi 622		ntinuous	Severe	
. ,	J																
Have you faller	n DURING	G THE LAS	T 12 M	ONTHS	?	No		Only once, Two or more times Injury that required r					required m	edical			
	no injury attention																

	FAMILY I	HISTORY (Mark	k "X" if positive and list	approx. age i	f known.)				
		Mother	Father	Sist	er	Brother	Child		
Breast Cancer									
Ovarian Cancer									
Colon Cancer									
Prostate Cancer									
Heart Attack, stent, or bypass surgery									
Stroke									
High cholesterol									
High blood pressure									
Diabetes									
Dementia									
Aneurysm									
Sudden death or died in sleep <55 yrs	old								
		1	 MEDICAL HISTORY						
HAVE YOU	FVFR RFF		O WITH OR TREATED	FOR ANY O	F THE FOLL	OWING?			
High blood pressure			ophageal strictures	101171111	Migraine				
High cholesterol		Ulcers				Seizures			
Heart attack / angina / stent/ b	ypass	Irritable Bov	vel / Spastic Colon		Brain or spinal cord abnormalities				
Heart failure		Crohn's Dise			Nerve co	Nerve condition of hands or feet			
Heart valve abnormality		Ulcerative C	olitis		Skin dise	ease			
Abnormal heart rhythm		Colon polyp	S		Peripher	al artery disease	e (PAD)		
Diabetes		Diverticulos	is / diverticulitis		Anxiety				
Thyroid problems		Liver proble	ms		Depressi	Depression			
Bleeding or anemia		Kidney or bl	adder problems		Drug or	Drug or alcohol abuse or addiction			
Blood clots		Prostate pro			Dement				
Blood transfusion		Autoimmun			ADD				
Cancer		Fibromyalgia	a		Multiple	Sclerosis			
COPD / Emphysema		Osteopenia	/ osteoporosis		Other No	eurological or Ps	ychiatric Condition		
Asthma		Stroke or TI	4		Immune	Deficiency			
Sleep apnea		•		•		•			
OTHER:									
Hospital visits / Reason	Facility	Attending	Physician		Dates	Previous Surg	eries / Year		

NAME DATE										
	e list a	t all used /seen during past year)								
Physicians		Reason	, , , , , ,		Oth	ner Physician / Therap	ist / Chiroprac	tor	Reason	
Medical Supplier / DME company				For						
Local Pharmacy					Mail	Order Pharmacy				
MEDICATION LIST (List all prescription, non-prescription, supplements, herbals, other.)										
Name of Medication			Strength or	Dose			Frequency a	nd rout	ie	
Example: Ibuprofen			200mg	1			2 tablets	s by moi	uth 3 times a day	
				ALLEI						
ALLERGY	REA	ACTION			LLER	GY		REAC	TION	
				VACCI	ΝΔΤΙ	ONS				
	YEAR			VACCI	. 4/4	YEAR				YEAR
Influenza (Flu Shot)	TEAR	Pneum	ovax 23 (Pne	eumoni	a)	TEAN	Tetanus	/ pert	ussis (TDaP)	I LAN
Shingles					7				pertussis (dT)	
Hepatitis A		Prevnar 13 (Pneumonia) Hepatitis B					Gardasi			

SCREENING TESTS						
TEST	NONE	DATE IF DONE	DR. OR FACILITY	(FOR OFFICE USE) <b>RECOMMENDED</b>		
Colonoscopy						
Stool test for blood						
Pap smear / pelvic exam						
Mammogram						
Bone Density						
Prostate cancer screen						
Electrocardiogram (EKG)						
Eye exam / Glaucoma screen						
Hearing evaluation						
Hepatitis C Screening						
Abdominal Aortic Screening (abdominal ultrasound)						

_	cc		
-or	∩††	מחו	use:
OI.	OH	ILL	use.

## **COUNSELING:**

Χ		Education	Recommended	Scheduled
	Diet / Nutrition			
	Advance Directive			
	Smoking Cessation			
	Alcohol Use			
	Home Safety			
	Exercise			
	Vaccines			
	Diabetic Education (DSMT)			
	Safe Sex Practices			
	Aspirin therapy			
	Calcium and / or vitamin D therapy			
	Cognitive evaluation			
	Driving assessment			
	Social Services			

## **BRING TO OFFICE APPOINTMENT**