ExacCare
walk in clinic

MEDICARE PREVENTIVE PHYSICAL EXAM Today's Date:_____

☐ Initial Preventive Physical Exam (Welcome to Medicare Physical)	☐ Initial annual wellness visit	☐ Subsequent annual wellness visit

Patient Name	Date of Birth	Date of last physical exam	Medicare B eligibility date

SOCIAL HISTORY						
Tobacco	□ Current	Type:	Freq:	□ 2nd hand	□Never	□ Prior use: Quit date:
Alcohol	□ Never	☐ Occasional	☐ Daily	History of alcohol: (describe)		
Caffeine	□ Never	☐ Occasional	☐ Daily	How much:		
Drug Abuse	□ Never	☐ Occasional	☐ Daily	☐ Prior use	Quit date:	
History of drug abuse: (describe)						
Occupation				Exercise type/frequency		
Home environment	☐ Private home	☐ Assisted living	☐ Other: (describe)			

FAMILY HISTORY Use "X" to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart disease									
Stroke									
Kidney disease									
Obesity									
Genetic disorder									
Alcoholism									
Liver disease									
Depression or manic depressive disorder									
Colon or rectal cancer									
Breast cancer									
Other cancer									
Other:_____									

MEDICAL HISTORY				
Hospital visits since last office visit/reason	Facility	Attending physician	Date of hospital visit	Past surgeries (include date and description of any complications)

Patient Name:_____ Today's Date:_____

ALLERGY LIST	
Allergies	Type of reaction

MEDICATION LIST If noted elsewhere, indicate location:_____					
RX meds, dose, frequency, route	Date started	Date discontinued	Herbals, supplements, OTC drugs, substances of abuse	Date started	Date discontinued

PROBLEM LIST List any problems you are currently having.				
Acute problems (R=resolved)	Date Added	Managing physician	Date updated	Initial

PROBLEM LIST List any long term problems.				
Chronic problems	Date Added	Managing physician	Date updated	Initial

Patient Name:_____ Today's Date:_____

OTHER PHYSICIANS AND PROVIDERS OF CARE		
Name & specialty/provider type	Type of care	Date discontinued

DEPRESSION SCREENING		
Over the past two weeks, have you felt down, depressed, or hopeless?	☐ Yes	☐ No
Over the past two weeks, have you felt little interest or pleasure in doing things?	☐ Yes	☐ No

Do you have an Advanced Directive or Living Will? ☐ Yes ☐ No

Provider to sign here to indicate review/notation of pertinent history:_____