

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).
- **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 to bill your insurance 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 15 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.

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 IN THEIR BOTTLES.

QUEST LAB:

QUEST IS LOCATED ON SITE AT AGEWELL AND YOU CAN SCHEDULE AN APPOINTMENT TO HAVE YOUR LABS DONE ONCE YOU ARE ESTABLISHED WITH YOUR PROVIDER.

WE ASK ALL AGEWELL PATIENTS TO USE QUEST EITHER AT AGEWELL OR A QUEST SERVICE SITE LOCATION CONVENIENT FOR YOU

Name: _____