Marc Kress, M.D. & Associates

FAMILY PRACTICE

610 Old York Road
Suite 70
Jenkintown, PA 19046
(215) 887-3100

Dear Medicare Patient:

Congratulations on setting up your Annual Medicare Wellness Exam with Dr. _____

on: _____ at:_____.

Please be on time and bring the following with you:

- Your Insurance ID cards and photo ID
- All of your medications and supplements in a bag – EVERYTHING YOU TAKE
- The COMPLETED 1-page **'Review of Systems"** Questionnaire – **Just circle Y or N for each.**
- The COMPLETED 4-page **"Health Risk Assessment"** form. Do your best. This form is to measure any CHANGES from year to year. If you have any questions, the Medical Assistant can help you during your appointment. ☺

Please note that the Medical Wellness Benefit does not have a copay and is for the purposes of reviewing your medical history and risk factors, and making a personalized prevention plan to help keep you healthy. This visit does not include the discussion or treatment of new or current medical problems, or a physical exam. If that occurs, it will be billed separately and related copays may be applicable.

Completing this information ahead of time for us will help the doctor get an overview of your current health and focus on the topics that matter most for your prevention plan. Because this type of visit is complex and time consuming, please understand that if you arrive more than 15 minutes late for your assigned arrival time or come without this paperwork, you may be asked to reschedule this visit.

We appreciate the trust you have placed in us to take care of your health care needs and hope that you will take advantage of this great Medicare benefit and work with us in creating your personalized prevention plan.

Sincerely,

Drs. Kress, Altobelli, Ukwu & Lewcun

SUITE 70

PATIENT NAME: _____ DOB: _____ DATE: _____

14-POINT REVIEW OF SYSTEMS: PLEASE CIRCLE CURRENT SYMPTOMS

CONSTITUTIONAL: Fever Chills Night sweats Fatigue
Weight Gain/Loss Changes in appetite

EYES: Changes in vision Decreased acuity Double vision Blurred vision
Eye pain Drainage Itching Excessive tearing Swelling/Lumps

EARS: Hearing loss Pain Drainage Ringing/noise Clogged sensation

NOSE: Bleeding Congestion Drainage Loss of smell Post-Nasal Drip

MOUTH/THROAT: Mouth/Lip sores Tongue sores Sore throat Hoarseness of voice
Teeth or gum issues

HEAD/NECK: Neck Pain Neck stiffness Swollen glands

SKIN: Rash Growths Abnormal bruising Itching Sores
Change in skin color Large moles

RESPIRATORY: Wheezing Shortness of breath Difficulty breathing Cough
Pain with breathing Coughing up blood Coughing up mucous

CARDIOVASCULAR: Chest pain Palpitations Passing out
Leg swelling Varicose veins Pain in leg(s) with walking

GASTROINTESTINAL: Nausea Vomiting Diarrhea Constipation Abdominal pain
Excessive belching Indigestion Change in bowel habits
Fecal incontinence Hemorrhoids Rectal bleeding

GENITOURINARY: Painful urination Urinary frequency / hesitancy Blood in urine
Excessive nighttime urination Urine leakage/incontinence Diminished urine flow
Flank or groin pain Erectile dysfunction Testicular pain Penile discharge
Missed menstrual cycle Abnormal vaginal bleeding Vaginal discharge or itching

MUSCULOSKELETAL: Muscle pain/Cramps Back pain Joint pain/ Stiffness /Swelling
Recent fractures Recent falls Trouble walking

NEUROLOGICAL: Headaches Dizziness Numbness Weakness on one side Tingling
Slurred speech Seizures Tremors Stumbling Memory loss

PSYCHIATRIC: Anxiety Depression Irritability Anger Personality change
Hallucinations Sleep disturbance Domestic violence Suicidal thoughts

I HAVE NONE OF THE ABOVE

Health Risk Assessment

Name	DOB	Date

Personal Medical History (check all that apply)					
Condition	Yes	Condition	Yes	Condition	Yes
Abnormal Bleeding		Asthma or Emphysema		Blood Clots	
Cancer		Indicate type:			
Congestive Heart Failure		COPD		Depression or Anxiety	
Diabetes		Heart Disease		Hepatitis	
High Blood Pressure		High Cholesterol		HIV or AIDS	
Joint Problems		Kidney Disease		Organ Transplant	
Pacemaker		Stroke		Thyroid Disorder	
Other (please specify)					

Surgical History (use additional sheet if necessary)	
Date	Surgery/ Procedure

Family History (check all that apply and indicate affected family member: mother, father, brother, sister, son, daughter)					
Condition	Yes	Relation	Condition	Yes	Relation
Abnormal Bleeding or Clotting			Breathing Disorder		
Cancer			Congestive Heart Failure		
Depression or Anxiety			Diabetes		
Heart Disease			High Blood Pressure		
High Cholesterol			Joint Problems		
Stroke			Thyroid Disorder		
Other (please specify)					

Health Risk Assessment

Name	DOB	Date

List the names of all your doctors (use additional sheet if necessary)

Name	Specialty	Reason

List your current medications. Be sure to include prescriptions, inhalers, over the counter medications, vitamins, supplements, ointments, creams, eye drops and patches (use additional sheet if necessary)

Name	Dosage

List of allergies (use additional sheet if necessary)

Allergy	Reaction

Hospitalizations and ER visits in the past year (use additional sheet if necessary)

Date	Reason

Health Risk Assessment

Name	DOB	Date

How would you rate the following?

Overall Health	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
Physical Health	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
Emotional Health	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
Eyesight (compared to last year)	☐ Same	☐ Slightly Worse	☐ Much Worse		
Hearing (compared to last year)	☐ Same	☐ Slightly Worse	☐ Much Worse		

How much pain have you had over the past 4 weeks?

☐ None ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

Please answer the following questions

During the past two weeks, have you:

Felt down, depressed or hopeless?	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Had little interest in doing things?	☐ Not at all	☐ Some days	☐ Most days	☐ Every day
Have you fallen within the past year?	☐ No	☐ Yes	How many times?_____	
Are you afraid of falling or do you worry about falling?	☐ No	☐ Yes		
Do you have problems with balance?	☐ No	☐ Yes		
Have you broken a bone?	☐ No	☐ Yes		
Have you had a bone mineral density test?	☐ No	☐ Yes		
Do you experience urinary leakage?	☐ No	☐ Yes		
Does urinary incontinence interfere with your routines in any way?	☐ No	☐ Yes		

Nutrition and Exercise Habits

How many servings of fruits and vegetables do you typically eat each day? _____

How many servings of high fiber foods or whole grains do you typically eat each day? _____

How many servings of fried or high fat foods do you typically eat each day? _____

How many sugar sweetened beverages do you typically drink each day? _____

How often do you engage in physical activity (walking, swimming, cycling, etc.) for at least 20-30 minutes?

_____

Immunizations

Have you had a flu vaccination within the past year?	☐ Yes	☐ No
Have you had a pneumonia vaccination?	☐ Yes	☐ No
Have you had a shingles vaccination?	☐ Yes	☐ No
Have you had a Covid-19 vaccination?	☐ Yes	☐ No

Health Risk Assessment

Name	DOB	Date

Home Safety and Activities of Daily Living

Do you have trouble with the stairs inside or outside your home?	☐ Yes	☐ No
Do you have hazards inside the home such as lack of grip bars in the bathtub, loose rugs or poor lighting?	☐ Yes	☐ No
Does your home have a carbon monoxide monitor?	☐ Yes	☐ No
Can you get out of bed by yourself?	☐ Yes	☐ No
Can you dress yourself?	☐ Yes	☐ No
Can you make your own meals?	☐ Yes	☐ No
Can you do your own shopping?	☐ Yes	☐ No
Can you bathe yourself?	☐ Yes	☐ No
Can you do your laundry/housekeeping?	☐ Yes	☐ No
Can you manage your money, pay your bills and track your expenses?	☐ Yes	☐ No
Do you leave your home to run errands, go to work, meetings or religious or social functions (not counting doctor visits)?	☐ Yes	☐ No

Social Habits

Do you smoke or use other tobacco products?	☐ Yes	☐ No
Have you smoked or used other tobacco products in the past?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No
Do you drive?	☐ Yes	☐ No
Do you use seat belts?	☐ Yes	☐ No
Do you understand why you're prescribed your medications?	☐ Yes	☐ No
Are you taking your medications as directed by your doctor?	☐ Yes	☐ No
Do you experience any side effects from your medications?	☐ Yes	☐ No
Please describe:	☐ Yes	☐ No
Are you concerned about the cost of your medications?	☐ Yes	☐ No
Do you ever forget to take your medications?	☐ Yes	☐ No

Advance Directives

Have you decided who would speak for you and make health care treatment choices for you if you became ill and could not make them for yourself?	☐ Yes	☐ No
If you answered "yes" to the question above, have you spoken to that person about your choices?	☐ Yes	☐ No
Have you completed a written advance directive (living will and/or health care power of attorney)?	☐ Yes	☐ No

Office Use Only Provider: _____ Date: _____

Place health risk assessment in the patient's chart