Southern Medical Group

Internal Medicine

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Board Certified
Internal Medicine

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Dear Patient,

Medicare/Medicare Advantage Plans require additional information to be reported by the patient for an annual wellness visit. In order to comply with the rules set forth by Medicare and to provide you with the best care possible, we ask that you answer the following questionnaire. Please bring the **completed** forms to your appointment which is scheduled on _____.

Sincerely,

Southern Medical Group

❑ **Weisgarber Location**
Southern Medical Group
6600 Nightingale Lane
Knoxville, TN 37909
(865) 632-5885

❑ **South Grove Location**
Southern Medical Group
7564 Mt. Grove Drive
Knoxville, TN 37920
(865) 632-5885

PATIENT QUESTIONNAIRE

Patient Name _____ Date ____/____/____

FAMILY HISTORY
use ✓ to indicate positive history

	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Diabetes									
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: _____									

SOCIAL HISTORY

Tobacco use:
Ever used tobacco? ❑ Yes ❑ No If yes: Year started using _____
Still using tobacco? ❑ Yes ❑ No If no: Year quit using _____
Type of tobacco used: (check all that apply) ❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Snuff/Chew

Alcohol use: ❑ Never ❑ Daily ❑ Occasional

Illegal Drug use: ❑ Yes ❑ No If yes, describe._____

OTHER PHYSICIANS AND PROVIDERS OF CARE

Name & specialty/provider type	Type of care	Date of last visit

ADVANCE DIRECTIVE

Do you have a healthcare Power of Attorney? ❑ Yes ❑ No
Do you have a living will? ❑ Yes ❑ No
If yes, please bring a copy to your visit.

Please complete all pages and bring with you to your visit

PATIENT QUESTIONNAIRE

Patient Name _____ Date ____/____/____

Home Safety Questionnaire

You may be at greater risk for falling. You can help prevent falls. Think about your home and make it safer for you.

Please mark the best answer for each of the questions below.

When I walk from room to room, I do not slip or stumble over electrical cords, low furniture or other things in my path.	❑ True	❑ False
When I walk from room to room, there are sturdy things I can grab if I feel unsteady or feel like I am going to fall.	❑ True	❑ False
I have good light when I walk in my house, even at night when going to the bathroom.	❑ True	❑ False
While inside my home I walk in shoes or in slippers.	❑ True	❑ False
I do not slip or have a hard time getting on and off the toilet.	❑ True	❑ False
I do not slip or have a hard time getting in and out of the bath or shower.	❑ True	❑ False
I do not slip or have a hard time with steps or stairs in my house.	❑ True	❑ False
I do not have to stand on my toes to get things out of reach in my kitchen or closets.	❑ True	❑ False
Outside my home, there are no uneven surfaces, cracked sidewalks, slippery steps or other problems that would make me trip or stumble.	❑ True	❑ False
If I were to fall, hurt myself and were unable to get up, I would be able to get help quickly.	❑ True	❑ False

- **Talk to your doctor if you have fallen 2 or more times in the past 6 months.**
- **Be sure to tell your doctor about recent falls or injuries.**

PATIENT QUESTIONNAIRE

Patient Name _____ Date _____/_____/_____

Risk Questionnaire

In general, how would you rate your health, compared to other people your age:

❑ Poor ❑ Fair ❑ Good ❑ Excellent

How much difficulty, <u>on average</u>, do you have with the following physical activities:

	No Difficulty	A little Difficulty	Some Difficulty	A lot of Difficulty	Unable to do
Stooping, crouching or kneeling?	❑	❑	❑	❑	❑
Lifting, or carring object as heavy as 10 pounds?	❑	❑	❑	❑	❑
Reaching or extending arms above shoulder level?	❑	❑	❑	❑	❑
Writing, or handling and grasping small objects?	❑	❑	❑	❑	❑
Walking a quarter of a mile?	❑	❑	❑	❑	❑
Heavy housework such as scrubbing floors or washing windows?	❑	❑	❑	❑	❑

Because of your health or a physical condition, do you have difficulty:

Shopping ?	❑ Yes	❑ No
Managing money and/or paying bills ?	❑ Yes	❑ No
Walking across the room ?	❑ Yes	❑ No
Doing light housework (like washing dishes, laundry, or light cleaning) ?	❑ Yes	❑ No
Bathing or showering ?	❑ Yes	❑ No

Completed by _____ Relationship to Patient _____

NAME:_____ DATE:_____

Please list any medical illness you have or have had in the past:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Please list any and all operations you have had in the past:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

If you are a NEW PATIENT please list your medications below:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

If you are a NEW PATIENT please list any drug allergies:

1._____
2._____
3._____
4._____

Please list the following:

Marital Status:_____

Children: _____
_____
_____
_____

Occupation: _____

Please answer the following questions by circling yes or no:

Have you experienced a lack of interest or pleasure in doing things?
yes no

Do you feel down , depressed or hopeless?
yes no

Do you have trouble falling asleep, staying asleep, or sleeping too much?
yes no

Do you feel tired or have a lack of energy?
yes no

Do you have trouble concentrating on things such as reading or watching television?
yes no

Do you feel fidgety or restless?
yes no

Do you have thoughts of suicide or of harming yourself?
yes no

Name_____ **Date:** _____

PLEASE CHECK THE ITEMS BELOW WHICH APPLY TO YOU

Weight change ____
Fatigue ____
Weakness ____
Sweats ____
Chills ____
Hot flashes ____
Insomnia (can't sleep) ____
Irritability ____
Dizziness or spinning ____
Swollen Glands ____
Memory Loss ____
Headaches ____
Passing out spells ____
Seizures ____
Concussion ____

Skin

Rashes ____
Itching ____
New moles ____
Bruises ____

Extremities

Nail Changes ____
Swelling ____
Pain ____
Ulcers ____

Eyes

Do you wear glasses? ____
Date of Last Exam ____
Glaucoma ____
Pain ____
Redness ____
Operations ____

Ears

Change in hearing ____
Discharge ____
Pain ____
Ringing ____

Skeletal

Dexa Scan (Yr) ____

Resipratory

Frequent colds ____
Sinus trouble ____
Postnasal drip ____
Nosebleeds ____
Snoring ____
Cough ____
Color ____
Any blood ____
Sore Throats ____
Sputum production ____
Shortness of breath ____
Wheezing ____
Pneumonia ____
Chest Disease ____

Breasts

Swelling ____
Lumps ____
Pain ____
Discharge ____
Date of Last Mammogram ____
Do you do self exams? ____

Heart

Chest pain ____
Shortness of breath ____
Palpitations ____
Swelling of legs ____
Murmur ____
High cholesterol ____

Genitalia

Impotence ____
Infertility ____
Tumors ____
Congenital abnormalities ____
Last Pap smear ____

Neurology

Strokes ____
Paralysis ____

Gastrointestinal

Difficulty Swallowing ____
Heartburn ____
Ulcers ____
Nausea ____
Vomiting ____
Stomach Pain ____
Gallstones ____
Change in bowels ____
Blood in bowels ____
Vomiting blood ____
Last Colonoscopy (Yr) ____

Urinary

Pain ____
Do you wake up at night to urinate? ____
Kidney stones ____
Increased urination ____
History of sexually transmitted disease ____
Discharge ____
Blood ____
Incontinence ____

Joints

Pain ____
Weakness ____
Gout ____
Tremor ____
Numbness ____
Back pain ____

Immunizations

Year of last Tetanus ____
Year of Pneumovax ____
Year of last Flu shot ____
History of Zostavax ____

Endocrine

Diabetes ____
Thyroid ____
On steroids (ever) ____