EVANS MEDICAL GROUP, P.C.
Caring for the Whole Family
465 North Belair Road, Suite 1B, Evans, Georgia 30809, 706-868-3100 office, 706-228-3125 fax

Dear Patient,

We are glad you are coming in for your preventive care visit. Please be aware that this visit is not for dealing with your medical problems, we address those needs on other visits, preventative visits are to do the following:

- Make sure your medical record is up-to-date and accurate.
- Review your overall health status.
- Review your social situation and your lifestyle choices.
- Talk about advance directives and living wills.
- Order any screening tests that are appropriate in order to help prevent disease.
- Give you a "roadmap" of what preventive care has been done in the past, and when you will be due for tests in the future.

Be aware that much of the care related to this visit is done outside of the exam room. These visits give us time to cover things that we usually can't cover while you are here for your problem recheck appointments.

We follow recommended guidelines for preventative care, but these are not “written in stone”. We will attempt to develop a plan just for you. As you age or your disease process changes, your preventative care plan may change as well.

Types of screenings to be done:
- Heart disease & stroke prevention
- Diabetes
- Cholesterol problems
- Colon & Prostate cancer
- High Blood pressure
- Osteoporosis & Bone loss
- Breast Cancer

We will also give you the opportunity to catch up on any recommended immunizations.

We look forward to providing this service to you and will see you soon.

With regards,

Evans Medical Group

You are scheduled for a Medicare preventive care physical in the near future. To make this visit as helpful and efficient as possible, it is *critical* that you carefully review and complete the form below. If you need help from family members, please ask them. If this questionnaire is not filled out prior to the visit and returned to our office, we will have to reschedule your appointment to give you time to do so. It is very important.

Mediations

Please review your medications ***carefully***. List them below…

Medication Name Dosage Prescribed by

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________
7.____________________
8.____________________
9.____________________
10.____________________
11.____________________
12.____________________

(If any other, please add them to a separate piece of paper.)

Problems

Please review your medical problems or the reasons your doctors treat you and list them *below.*

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________
7.____________________
8.____________________
9.____________________
10.____________________
11.____________________
12.____________________

(If any other, please add them to a separate piece of paper.)

Allergies

List all medication allergies below. This list includes any medication you have had a problem with, not just allergies. (Ex: penicillin causes hives or Erythromycin causes severe stomach pain)

1.____________________
2.____________________
3.____________________
4.____________________
5.____________________
6.____________________

Surgeries

List below, any surgeries you have had, the year, and who did them.

Type of Surgery | Year performed: | Performed by:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

Hospitalizations

Have you ever been in the hospital? Please list when, where, and for what reason for each time:

Hospital stay date: | Name of Hospital: | Reason:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

Injuries

Please list any injuries you have had. (Ex: concussion due to fall from a stool, 2009; tripped on curb & broke right femur/leg, 2007, etc)

____________________ ____________________

____________________ ____________________

____________________ ____________________

Consultants

Please list below ALL the doctors that you see and what kind of doctor they are. (Ex: Dr. Smith, cardiology/heart doctor; Dr. Pitts, gastroenterologist/stomach doctor; Dr. Joseph, lung doctor; Dr. Lentz, psychiatry, etc.)

Name of DOCTORS | Type of doctor:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

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Upcoming Appointments

What appointments do you have coming up with any of your doctors?

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

Activities of Daily Living/Function

Answer the following questions by circling your answer and giving a short explanation.

1) Do you have difficulty hearing? Yes No Do you wear a hearing aid? Yes No
2) Do you need help with bathing? Yes No
3) Do you need help with dressing? Yes No
4) Do you need help moving from a chair to the bed? Yes No
5) Are you able to control urination and bowel movement? Yes No
6) Can you feed yourself without help? Yes No
7) Have you fallen in the past 6 months? Yes No When? ______________________________
____
8) Do you have a home that meets your needs? Yes No
9) Does your home have heat and air conditioning? Yes No
10) Are you homebound? Yes No
11) Do you have transportation? Yes No
12) Do you have sufficient food? Yes No
13) Do you have access to a telephone? Yes No
14) Have you been abused or threatened physically or emotionally? Yes No
15) Have you been abused sexually? Yes No
16) Do you feel safe at home? Yes No
17) Do you have difficulties with balance? Yes No
18) Do you have dizziness/lightheadedness when you change positions? Yes No
19) Do you have episodes of dizziness? Yes No
20) Have you experienced blackouts? Yes No

Comments: ____

____

Lifestyle/Social

Please review and correct the information below:

1) Marital status ?
2) Who lives in the home with you?
3) Alcohol use? Yes No
   Number of drinks per day?:
   Type of alcohol?
4) Illegal drug use? Yes No
   Type of drug(s)?
5) How often do you exercise per week?
6) Type of exercise:
7) How good is your diet? Excellent Good Fair Poor

8) Are you sexually active? Yes No
9) Do you smoke? Yes Quit Never Smoked
Year started: _________________ Packs/day: ____________________
Year Quit: _________________

Depression Screening
1) During the past month have you been bothered by feeling down, depressed, or hopeless? Y N
2) During the past month have you been bothered by little interest or pleasure in doing things? Y N
3) Do you have a history of depression? Yes No
If yes, have you ever been hospitalized for it? When? Where?________________________

Advanced Directives
Please answer the following (circle):

Do you have a living will? Yes No
Would you like to know more about a living will? Yes No
Do you have a medical power of attorney? Yes No
Would like to know more about a medical power of attorney? Yes No

Tests Done
Please put the dates of the tests below. If you have not had these, write "none"

Date of last colonoscopy: __________ Where done & by whom? _____________________
Date of last prostate cancer screening?______________________
Date of last mammogram?_______________________________
Date of last bone density?_________________________ by whom? _____________________
Date of Abdominal Aortic Aneurysm screening? ______ by whom? _____________________
Date of Heart (Coronary) Calcium Score? __________________ by whom? _____________________
Have you had a cholesterol test done anywhere besides our office? Yes No

Immunizations/Vaccines
Please write the dates of the last vaccines given or give explanation of why they weren't given.

Have you had a Tetanus shot in the past 10 years? Yes No I don't know
Date ____________ kind: Tdap Td I don't know
where done? _______________

Have you ever had a Pneumonia Shot? Yes No I don't know

Flu vaccine: date__________ where done? _________________

Zostavax (Shingles vaccine) date: ___________ where done? _______________

Hepatitis B Vaccine: date: _______________ where done? _______________

RETURN this questionnaire by mail or drop off to:
Evans Medical Group
465 North Belair Road, Ste 1B
Evans GA 30809