GUSTAVO H. DAY M.D.
INTERNAL MEDICINE

MEDICARE REPLACEMENT

GUSTAVO H. DAY. M.D., P.A.

Name: ______________________________

Date of Birth: ______________________________

Today's Date: ______________________________

Sex: M _____ **F** _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widow

List all the members of your household:

____

____

____

____

Which pharmacy do you use?

____

____

Please indicate your occupational status.

○ Retired
○ Unemployed
○ Currently employed
○ Disabled

In general, would you say your health is:

○ Excellent
○ Very Good
○ Good
○ Fair
○ Poor

Do you smoke or have you smoked in the part?

○ Never smoked
○ Don't smoke, I quit smoking inthe part 5 years.
○ Don't smoke, I quit smoking more than 5 years ago.
○ Yes, I might quit
○ Yes, but I'm not ready to quit

Do you drink alcohol? YES ☐ NO ☐

Please estimate how many alcohol drinks per week:

○ **10 or more per week**
○ **6 - 9 per week**
○ **2 - 5 per week**
○ **1 or less per week**
○ **No alcohol at all**

If you do drink alcohol (circle the appropriate answer):

1. Have you ever felt you needed to Cut down on your drinking?

   YES ☐ **NO** ☐

2. Have people Annoyed you by criticizing your drinking?

   YES ☐ **NO** ☐

3. Have you ever felt Guilty about drinking?

   YES ☐ **NO** ☐

4. Have you ever felt you needed a drink first thing in the morning (Eye-opener) to steady your nerves or to get rid of a hangover?

   YES ☐ **NO** ☐

Does the patient have any allergies?

○ **YES** ○ **NO**

Medication Allergies / Reaction:

Food Allergies / Reaction:

Airborne or Pollen Allegy / Reaction:

Animal or Insect Allergy / Reaction:

Other Allergies:

____

____

____

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If applicable, please list any childhood illnesses and/or disorders that you experienced?

Family Histoy (Please list all medical conditions or diseases):

Father:

Mother:

Siblings:

Children:

Please list al existing medical conditions here

Please list all patient's hospital stays

Please list all medications the patient is currently taking (Including over the counter medications or supplements)

Vaccinations and Routine Exams

Please indicate the last year you had the following vaccinations or routine exams. If you do not know, you may say "Don't know". If you have never had the vaccination or exam, say "Never had".

Please indicate the last year you had a Hepatitis B shot

Flu vaccine

Pneumonia vaccine

Tetanus Diptheria (TD) vaccine

Zostavax vaccine (for shingles)

Bone density scan

Colonoscopy

Glaucoma or eye exam

Gluose (blood sugar) test

Fecal occult blood (blood stool) test

Lipid panel or profile (cholesterol)

Medical Nutrition Therapy counseling

(MEN)

Prostate exam

PSA exam (Prostate Specific Antigen - often part of lab work)

(WOMEN)

Mammogram

Pap test

Pelvic exam

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The next few questions are about your dairy functional activities. Plase describe best how you perform the following activities.

Feeding yourself, preparing meals

- ◯ I can do myself
- ◯ I need assistance
- ◯ I sometimes need assistance

Getting from bed to chair, walking across the room (including using cane or walker)

- ◯ I can do myself
- ◯ I need assistance
- ◯ I sometimes need assistance

Getting to the bathroom, bathing or showering, getting dressed

- ◯ I can do myself
- ◯ I need assistance
- ◯ I sometimes need assistance

Using the telephone

- ◯ I can do myself
- ◯ I need assistance
- ◯ I sometimes need assistance

Driving a vehicle

- ◯ I can do myself
- ◯ I need assistance
- ◯ I sometimes need assistance
- ◯ I do not drive

Taking your medicines (if applicable)

- ◯ I can do myself
- ◯ I need assistance
- ◯ I sometimes need assistance

Managing money (including keeping track of expenses & paying bills)

- ◯ I can do myself
- ◯ I need assistance
- ◯ I sometimes need assistance

Moderate housework (such as doing laundry & doing dishes)

- ◯ I can do myself
- ◯ I need assistance
- ◯ I sometimes need assistance

Shopping for groceries, clothing, etc.

- ◯ I can do myself
- ◯ I need assistance
- ◯ I sometimes need assistance

Climbing a flight of stairs

- ◯ I can do myself
- ◯ I need assistance
- ◯ I sometimes need assistance

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What type of diet do you follow? Check all that apply

- ◯ I don't follow a diet
- ◯ Balanced
- ◯ Vegetarian
- ◯ Diabetic
- ◯ Low Salt
- ◯ Low Fat
- ◯ Low Carb
- ◯ Gluten Free

Do you do some form of exercise on a regular basis?

- ◯ Yes
- ◯ No

If you said that you do some form of exercise on a regular basis, how often do you exercise?

- ◯ 0 - 30 minutes per day
- ◯ 30 - 60 minutes per day
- ◯ < 1 hour per week
- ◯ 1 - 2 hours per week
- ◯ 3 - 4 hours per week

Are you currently experiencing any sexual health problems?

- ◯ Yes
- ◯ No
- ◯ Decline to answer

Do you brush your teeth/dentures daily?

- ◯ Yes
- ◯ No
- ◯ Sometimes

Do you visit a dentist regularly?

- ◯ Yes
- ◯ No
- ◯ Sometimes
- ◯ I wear dentures

How often is stress a problem for you?

- ◯ Never/Rarely
- ◯ Sometimes
- ◯ Often
- ◯ Always

How well do yo handle stress in your life?

- ◯ I am usually able to cope effectively
- ◯ At times, I have problems coping
- ◯ I often have problems coping

Do you use a hearing ald?

- ◯ Yes
- ◯ No
- ◯ Sometimes

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Do you find it hard to follow a conversation at a public meeting, religious service, or in a noisy restaurant?

- ◯ Yes
- ◯ No
- ◯ Sometimes

Do you find yourself asking people to speak up or repeat themselves?

- ◯ Yes
- ◯ No
- ◯ Sometimes

Do you experience ringing or noises in your ears?

- ◯ Yes
- ◯ No
- ◯ Sometimes

During the month, have you been bothered by feeling down, depressed, hopeless or little interest or pleasure in doing things?

- ◯ Yes
- ◯ No

Have you dropped many of your activities and interests?

- ◯ Yes
- ◯ No

Do you feel that your life is empty?

- ◯ Yes
- ◯ No

Do you often get bored?

- ◯ Yes
- ◯ No

Are you afraid that something bad is going to happen to you?

- ◯ Yes
- ◯ No

Do you feel happy most of the time?

- ◯ Yes
- ◯ No

Do you prefer to stay at home, rather than going out and doing things?

- ◯ Yes
- ◯ No

Do you feel that you have more problems with memory than most?

- ◯ Yes
- ◯ No

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Have you fallen in the part year?

- ◯ Yes
- ◯ No

Is the patient afraid of falling?

- ◯ Yes
- ◯ No
- ◯ Sometimes

Has the patient fallen in the part 6 months?

- ◯ No
- ◯ Yes, I have fallen in the past 6 months and did NOT require medical attention
- ◯ Yes, I have fallen in the past 6 months 2 or more times and DID require medical attetion

If you said that you have fallen in the past 6 months. Please check all conditions surrounding that fall or falls.

- ◯ Able to get up on own
- ◯ Not able to get up on own
- ◯ Lightheadedness
- ◯ Loss of consciousness
- ◯ Injured
- ◯ Needed to see a doctor
- ◯ Tripped over something

Do you use a walker, cane or need assistance going around?

- ◯ Yes
- ◯ No
- ◯ Sometimes

Do you lose your balance, feel unsteady or stagger when walking?

- ◯ Yes
- ◯ No
- ◯ Sometimes

Have you experienced a stroke, accident or any other health problems that may have affected your balance?

- ◯ Yes
- ◯ No

Do you have a living will in place?

- ◯ Yes
- ◯ No
- ◯ I don’t know

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Do you have a health care power of attorney (POA) in place?

- ◯ Yes
- ◯ No
- ◯ I don't know

Do you have a DNR (also know as NO code or AND) in place?

A do not resuscitate order, or DNR, is a medical order written by a doctor. It instructs health care providers not to do cardiopulmonary resuscitation (CPR).

- ◯ Yes
- ◯ No
- ◯ I don't know

Are you seeing any other doctor?

- ◯ Yes
- ◯ No

Please list all of the physicians and practitiones that you are currently seeing.

____

____

____

Do you use the services of a therapist(s)?

Examples include mental health counselors, psychologistss, massage therapists or alternative medicine providers.

- ◯ Yes
- ◯ No
- ◯ I don't know

Please list all of the therapists you are currently seeing

Do you (sometimes) use the services of a home health care company, D.M.E. (Durable Medical Equipment) or H.M.E. (Home Medical Equipment) company?

- ◯ Yes
- ◯ No
- ◯ I don't know

Which D.M.E. H.M.E., or health care company do you use?

____

____

______________________________ ______________________________

Physician's Signature **Date**