Viraj V. Tirmal, MD
Internal Medicine

*Viraj V. Tirmal, MD LLC*

Name:_____

Date of Birth:_____Today's Date:_____

# Medicare/Insurance/Combined Annual Wellness Exam

## Annual Preventative Questions

**Please check if any of the following applied to you in the last year. If you completed this form last year or more recently, please provide updates:**

**Diet and Nutrition**

| | |
|---|---|
| diet is high in salt | ☐ |
| diet is high in fat, low in fiber | ☐ |
| high caloric intake | ☐ |
| high carbohydrate meals | ☐ |
| low calcium intake | ☐ |

**Fracture Risk**

| | |
|---|---|
| history of fractures | ☐ |
| recent explained fracture | ☐ |
| sudden unexplained fractures | ☐ |
| previous musculoskeletal injuries | ☐ |

**Physical Activity**

| | |
|---|---|
| exercises on a regular basis | ☐ |
| physical activity | recent increase ☐ decreased ☐ |
| physical condition | good ☐ poor ☐ |
| deconditioned due to sedentary lifestyle | ☐ |

**Sleep**

| | |
|---|---|
| trouble sleeping | ☐ |
| snore | ☐ |
| insomnia | ☐ |
| takes excessive naps through out the day (more than 30 minutes) | ☐ |

**Patient Rated Health Status (pick one)**

| | |
|---|---|
| poor | ☐ |
| fair | ☐ |
| good | ☐ |
| very good | ☐ |
| excellent | ☐ |

**Depression Risk**

| | |
|---|---|
| feels sad, empty, or tearful | ☐ |
| loss of interest in activities | ☐ |
| significant changes in weight | ☐ |
| sleep disturbances or insomnia | ☐ |
| agitated | ☐ |
| loss of energy | ☐ |
| feelings of worthlessness or guilt | ☐ |
| thoughts of suicide | ☐ |
| history of mood disorders | ☐ |
| history of depression | ☐ |

**Orientation**

| | |
|---|---|
| disorientation to time | ☐ |
| disorientation to date | ☐ |
| disorientation to place | ☐ |

**Concentration and Memory**

| | |
|---|---|
| decreased concentrating ability | ☐ |
| memory lapses or loss | ☐ |
| forgetting words | ☐ |

**Speech/Motor difficulties**

| | |
|---|---|
| speech difficulties | ☐ |
| difficulty expressing formulated concepts | ☐ |
| difficulty with fine manipulative tasks | ☐ |
| difficulty writing/copying | ☐ |
| slowed reaction time | ☐ |
| knocking things over when trying to pick them up | ☐ |

**Stress**

under stress: ☐
type/source of stress: _____
support system ☐
stress level: low ☐ medium ☐ high ☐

**Hearing**

wears hearing aids ☐
loss of hearing right ear ☐ left ear ☐
fluctuating ☐
getting progressively worse ☐
difficulty hearing over background noise ☐
requires TV, radio at high volume ☐
tone deafness ☐

**Vision**

total vision loss ☐
worsening ☐
briefly vision loss ☐
worse with distance ☐
worse near ☐
seeing double images with fatigue ☐
blind spot(s) ☐
sudden partial vison loss ☐
slow partial vision loss ☐
increased sensitivity to glare ☐
difficulty seeing in bright light ☐
worsening depth perception ☐
blurred vision ☐

**Activities of Daily Living**

able to bathe with limited or no assistance ☐
able to control urination and bowels ☐
able to dress with limited or no assistance ☐
able to feed self with limited or no assistance ☐
able to get out of chair or bed with limited or no assistance ☐
able to groom with limited or no assistance ☐
able to toilet with limited or no assistance ☐

**Instrumental Activities of Daily Living**

able to do housework with limited or no assistance ☐
able to grocery shop with limited or no assistance ☐

able to manage medications with limited or no assistance ☐
able to manage money with limited or no assistance ☐
able to prepare meals with limited or no assistance ☐
able to use the phone with limited or no assistance ☐

**Falls Risk Assessment**
fall(s) since last visit ☐
frequent falls while walking ☐
fall(s) in the past year ☐
dizziness/vertigo ☐
fear of falling ☐
injury with fall ☐

**Home Safety**
number of motor vehicle accidents: _____
unsafe stairs ☐
unsafe flooring hazards ☐
unsafe gas appliances ☐
no smoke/CO detectors ☐
does not wear protective head gear for biking/high velocity ☐
does not use seatbelts ☐
not practicing 'safer sex' ☐
vision or hearing loss while driving ☐
fire arms ☐
does not have hand bars in the bathroom/shower ☐
poor lighting in the home ☐

**Additional Lifestyle Factors:**
tobacco use ☐
alcohol: no intake ☐ stopped drinking ☐
misuse ☐ drinks mild-moderate ☐
intimate partner violence ☐
high risk sexual behavior ☐

**Screening Exams:**
Last colonoscopy/Cologuard/Stool FIT test: _____
Last mammogram: _____
Last DEXA scan: _____

Affiliated Physician MDVIP

Viraj V. Tirmal, MD
Internal Medicine

*Viraj V. Tirmal, MD LLC*

# REVIEW OF SYSTEMS

**Constitutional**

fever ☐
night sweats ☐
weight gain (lbs) _____ ☐
weight loss (lbs) _____ ☐
exercise intolerance ☐
lethargy ☐
insomnia ☐
snoring ☐
fatigue ☐

**Eyes**

last eye exam: _____
dry eyes ☐
irritation ☐
cataracts ☐
vision change ☐
glaucoma ☐
wears contacts ☐
wears glasses ☐

**Ears**

difficulty hearing ☐
ear pain ☐
tinnitus (ringing in ears) ☐
wears hearing aids ☐

**Nose**

frequent nose bleeds ☐
nose problems ☐
sinus problems ☐
nasal congestion ☐

**Mouth/Throat**

up to date with dental cleanings ☐
flosses ☐
sore throat ☐
bleeding gums ☐
dry mouth ☐
oral abnormalities ☐
mouth ulcer ☐
poor dentition ☐
mouth breathing ☐
thrush ☐
cold sores ☐

**Allergy/Immunologic**

runny nose ☐
sinus pressure ☐
itching ☐
hives ☐
frequent sneezing ☐

**Cardiovascular**

- chest pain on exertion ☐
- arm pain on exertion ☐
- shortness of breath when walking ☐
- orthopnea (shortness of breath with lying down) ☐
- palpitations ☐
- known heart murmur ☐
- light-headed on standing ☐
- paroxysmal nocturnal dyspnea (waking up in the middle of the night with severe shortness of breath and needing to sit on the side of the bed to catch your breath) ☐
- abnormal blood pressure ☐
- leg claudication (pain in calf after walking a certain distance) ☐

**Respiratory**

- cough ☐
- wheezing ☐
- shortness of breath ☐
- coughing up blood ☐
- sleep apnea ☐
- productive cough ☐

**Gastrointestinal**

- abdominal pain ☐
- vomiting ☐
- change in appetite ☐
- black or tarry stools ☐
- frequent diarrhea ☐
- vomiting blood ☐
- dyspepsia (indigestion) ☐
- esophageal reflux ☐
- constipation ☐
- difficulty swallowing ☐
- bright red blood per rectum ☐
- rectal bleeding ☐
- hemorrhoids ☐
- anorexia ☐
- bloating ☐
- early satiety ☐

**Genitourinary**

- urinary loss of control ☐
- difficulty urinating ☐
- increased urinary frequency ☐
- hematuria ☐
- difficulty emptying bladder ☐
- urgency ☐
- nocturia (waking up to pee in the middle of the night) # of times _____ ☐
- dysuria ☐
- dribbling ☐
- STDs ☐

**Musculoskeletal**

- muscle aches ☐
- muscle weakness ☐
- arthralgias/joint pain ☐
- back pain ☐
- swelling in the extremities ☐
- Raynaud's Phenomena (reduced blood flow to the fingers/toes with exposure to cold) ☐
- neck pain ☐

**Integumentary / Skin**

- abnormal mole ☐
- jaundice ☐
- rash ☐
- itching ☐
- dry skin ☐
- growths/lesions ☐
- laceration ☐
- nail problems ☐
- nail fungus ☐
- acne ☐
- rosacea ☐
- warts ☐
- urticaria (hives) ☐

**Neurologic**

- syncope ☐
- weakness ☐
- numbness ☐
- seizures ☐
- dizziness ☐
- frequent or severe headaches ☐
- migraines ☐
- restless legs ☐
- tremor ☐
- memory concerns out of the ordinary ☐

**Psychiatric**

- depression ☐
- sleep disturbances ☐
- feeling unsafe in relationship ☐
- restless sleep ☐
- alcohol abuse ☐
- anxiety ☐
- hallucinations ☐
- suicidal thoughts ☐

**Endocrine**

- increased thirst ☐
- hair loss ☐
- increased hair growth ☐
- cold intolerance ☐

**Hematologic/Lymphatic**

- history of transfusions ☐
- swollen glands ☐
- easy bruising ☐
- excessive bleeding ☐

# FAMILY HISTORY

**Please answer the following. If you completed this form last year, please provide updates, if applicable.**

Please list your parent's medical conditions, age of onset of those conditions (if known), and if deceased, age of death:

Father:

Mother:

Please list your sibling's names with their gender, how many years older/younger they are, their medical conditions, age of onset of those conditions (if known), and if deceased, age of death:

Please list your children's names with their gender, birth date/year, their medical conditions, age of onset of those conditions (if known), and if deceased, age of death:

# SURGICAL HISTORY

Please list any/all procedures you have underwent, date of the procedure (or approximate date), and who performed the procedure (if known):

Affiliated Physician
MDVIP

Viraj V. Tirmal, MD
Internal Medicine

*Viraj V. Tirmal, MD LLC*

# PROVIDER LIST

Please list all your other care providers with their area of expertise (specialists, dentist, optometrist, etc.):

Affiliated Physician MDVIP

Viraj V. Tirmal, MD
Internal Medicine

*Viraj V. Tirmal, MD LLC*

# SOCIAL HISTORY

**Please answer the following. If you completed this form last year, please provide updates, if applicable.**

**Substance Use:**

*Tobacco use:*

Have you ever smoked tobacco? Never ☐ Former ☐ Current ☐

How many years have you smoked tobacco?_____

At what age did you start smoking tobacco?_____

How much tobacco do/did you smoke?_____

When did you quit smoking?_____

Have you ever used any other forms of tobacco or nicotine? Yes ☐ No ☐

Have you ever used e-cigarettes or vape? Never ☐ Former ☐ Current ☐

Have you ever used smokeless tobacco? Never ☐ Former ☐ Current ☐

Date of most recent tobacco screening?_____

*Alcohol use:*

Level of alcohol consumption: None ☐ Occasional ☐ Moderate ☐ Heavy ☐

How many times per week do you consume alcohol?_____

How many alcoholic drinks do you consume per day on average?_____

How many days in the past year have you consumed 4 or more drinks?_____

Have you ever been counseled for unhealthy alcohol use?_____

*Illicit or Recreational Drugs:*

Do you use any illicit or recreational drugs? Yes ☐ No ☐

Which illicit or recreational drugs have you used?_____

*Caffeine:*

What is your level of caffeine consumption?

None ☐

1 cup per day ☐

2 cups per day ☐

3 cups per day ☐

**Diet and Exercise:**

What type of diet are you following?

- Regular ☐
- Vegetarian ☐
- Vegan ☐
- Gluten Free ☐
- Carbohydrate ☐
- Cardiac ☐
- Diabetic ☐
- Specific ☐ _____

Do you engage in light exercise (e.g. light walking, housework, etc)? Yes ☐ No ☐

How often are you engaging in light exercise?

- None ☐
- Less than monthly ☐
- 1-3 times per month ☐
- 1-3 times per week ☐
- 4-6 times per week ☐
- Daily ☐
- Other ☐ _____

Do you engage in moderate/heavy exercise (e.g. brisk walk, jogging, strength training, etc)?

Yes ☐ No ☐

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____

On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise? _____

**Marriage and Sexuality:**

What is your relationship status?

- Married ☐
- Single ☐
- Divorced ☐
- Separated ☐
- Widowed ☐
- Domestic partner ☐
- Other ☐

Are you sexually active? Yes ☐ No ☐

How many children do you have? _____

**Education and Occupation:**

What is the highest grade or level of school you have completed or the highest degree you have received?

- Never attended/kindergarten only ☐
- 1st grade ☐
- 2nd grade ☐
- 3rd grade ☐
- 4th grade ☐
- 5th grade ☐
- 6th grade ☐
- 7th grade ☐
- 8th grade ☐
- 9th grade ☐
- 10th grade ☐
- 11th grade ☐
- 12th grade, no diploma ☐
- GED or equivalent ☐
- High school graduate ☐
- Some college, no degree ☐
- Associate degree: occupational, technical, or vocational program ☐
- Associate degree: academic program ☐
- Bachelor's degree (e.g. BA, AB, BS) ☐
- Master's degree (e.g. MA, MS, MEng, Med, MSW, MBA) ☐
- Professional school degree (e.g. MD, DDS, DVM, JD) ☐
- Doctoral degree (e.g. PhD, EdD) ☐
- Don't know ☐
- Refused ☐

Are you currently employed? Yes ☐ No ☐

What is/was your occupation?_____

**Lifestyle**

Do you feel stressed (tense, restless, nervous, or anxious, or unable to sleep at night)?

- Not at all ☐
- Only a little ☐
- To some extent ☐
- Rather much ☐
- Very much ☐

Do you use your seat belt routinely? Yes ☐ No ☐

**Home and Environment Safety**

Do you have smoke and carbon monoxide detectors in your home? Yes ☐ No ☐
Are you passively exposed to smoke? Yes ☐ No ☐
Are there any guns present in your home? Yes ☐ No ☐
Do you use sunscreen routinely? Yes ☐ No ☐

**Public Health and Travel**

Have you recently traveled abroad? Yes ☐ No ☐
Where to?_____

**Activities of Daily Living**

Are you able to care for yourself? Yes ☐ No ☐
Are you blind or do you have difficulty seeing? Yes ☐ No ☐
Are you deaf or do you have serious difficulty hearing? Yes ☐ No ☐
Do you have difficulty concentrating, remembering or making decisions? Yes ☐ No ☐
Do you have difficulty walking or climbing stairs? Yes ☐ No ☐
Do you have difficulty dressing or bathing? Yes ☐ No ☐
Do you have difficulty doing errands alone? Yes ☐ No ☐
Do you have transportation difficulties? Yes ☐ No ☐
Which of your hands is dominant?

Right ☐
Left ☐
Bilateral ☐

**Advance Directive**

Do you have an advance directive? Yes ☐ No ☐
If you were to collapse and your heart was stopped, do you want me to try to revive you and send you to the hospital? Yes (Full Code) ☐ No (Do not resuscitate) ☐
Do you have an out of hospital DNR? Yes ☐ No ☐
Do you have a medical power of attorney? Yes ☐ No ☐
Is blood transfusion acceptable in an emergency? Yes ☐ No ☐



Submit