BIMGA
BEAUMONT INTERNAL MEDICINE & GERIATRIC ASSOCIATES

ANNUAL WELLNESS VISIT

PATIENT QUESTIONNAIRE

PHONE
(409) 898-2994
FAX
(409) 899-5542
EMAIL
Medicalrecords@bimga.com

PATIENT'S NAME _____ DATE OF BIRTH _____ DATE _____

TODAY'S VISIT

Wellness due today. Any complaints or concerns today? _____

_____

Are you needing any medications refilled today? ☐ YES ☐ NO

Did you bring a current medication list with you today? ☐ YES ☐ NO

In the past year, have you had any surgeries? ☐ YES ☐ NO

If yes, what surgery? _____

ADVANCE CARE PLANNING

Do you have any of the listed advance care plans? *Circle all that apply.*

Living Will **Medical Power of Attorney** **DNR** **Other:** _____

- *If you circled any of the advance care plans, please make sure your physician has a copy on file.*

If you were to suffer a life-altering event such as a **STROKE**, who best understands the care you would want?

_____

What are your health care wishes if you become unable to make your own decisions?

_____

When working through a crisis, who do you turn to for help? _____

Who have you named as your surrogate decision maker? _____ or circle: **NONE**

What kind of personal care would you accept? *Circle all that apply.*

Home Health **Hospice** **Nursing Home** **Private Care Providers** **Assisted Living** **Skilled Nursing**
Any Means Necessary **Depends on Circumstances** **Other:** _____

HEALTH STATUS

Have there been any changes in your health status over the past year? ☐ YES ☐ NO

Do you require the assistance of another person when traveling? ☐ YES ☐ NO

Are you compliant with taking medications as directed? ☐ YES ☐ NO

If no, please explain: _____

Are you compliant with keeping your doctor's visits? ☐ YES ☐ NO

If no, please explain: _____

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GENERAL HEALTH SCREENING

During the past 4 weeks, how would you rate your health?

Excellent **Good** **Fair** **Poor**

Which (if any) of the following are problems for you?

- ☐ I am tired or fatigued
- ☐ I experience a lot of stress or anger
- ☐ I am lonely or do not have a lot of support at home
- ☐ I have difficulty taking or remembering my medicines

Do you feel safe in your home? ☐ YES ☐ NO

Do you fasten your seatbelt when you are in the car? ☐ YES ☐ NO

Do you have any sexual problems you would like to discuss? ☐ YES ☐ NO

Do you have any problems with pain? ☐ YES ☐ NO

Do you exercise for 20 minutes, 3 or more days per week? ☐ YES ☐ NO

Do you follow any specific diet (ex. low sodium, low sugar)? ☐ YES ☐ NO

FUNCTIONAL STATUS ASSESSMENT

Are you able to perform activities of daily living (ADLs) independently (ex. groom, bathe, dress, eat, walk, use the bathroom, etc.)? ☐ YES ☐ NO

Are you able to perform ALL instrumental activities of daily living (IADLs) independently (ex. shopping for groceries, making food, managing finances, using the phone, laundry, routine housework, driving, using public transportation, taking medications, etc.)? ☐ YES ☐ NO

Do you have trouble with incontinence (leaking of urine)? ☐ YES ☐ NO

Do you see any specialists or other providers? If so, please list them below:

HOSPITAL & ER VISITS

How many times in the last 6 months have you been admitted to the hospital or emergency room? _____

RISK SCREENING

Do you have problems with your vision? ☐ YES ☐ NO

Do you have any problems with your hearing? ☐ YES ☐ NO

Do you have any problems with your teeth or dentures? ☐ YES ☐ NO

Are you, or your loved ones, concerned about your memory? ☐ YES ☐ NO

OPIOID USE

Do you take any opioid medications? ☐ YES ☐ NO

FALL RISK SCREENING

Have you had a fall in the last year? Please select from the following options:

- ☐ No falls to report in the last year
- ☐ 1 fall without injury in the last year
- ☐ 2–5 falls without injury in the last year
- ☐ 5+ falls without injury in the last year
- ☐ 1 fall with injury in the last year
- ☐ 2–5 falls with injury in the last year
- ☐ 5+ falls with injury in the last year

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SCREENINGS & HISTORY

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EYE EXAM

What was the date of your last routine eye exam? _____

Who was your eyecare provider? _____

Do you have Diabetic Retinopathy? *If yes, when was your last diabetic eye exam:* _____ ☐ YES ☐ NO

SOCIAL HISTORY SCREENING

Are you a smoker? *Circle one.*

Never Smoker **Former Smoker** **Current Smoker** **Occasional Smoker**

Have you used drugs other than those for medical reasons in the past 12 months? ☐ YES ☐ NO

Have you had a drink containing alcohol in the past year? ☐ YES ☐ NO

BREAST CANCER SCREENING

If you have had a mammogram, what was the date of your last mammogram? _____

If applicable, what was the location of your last mammogram? _____

COLORECTAL SCREENING

If you have had a colonoscopy, what was the date of your last colonoscopy? _____

If applicable, what were the results of your last colonoscopy?

Normal **Polyps** **Diverticulitis** **Unknown**

If applicable, who is your gastroenterologist? _____

Have you ever had a fecal occult blood test? *If yes, when:* _____ ☐ YES ☐ NO

Have you ever had a Cologuard screening? *If yes, when:* _____ ☐ YES ☐ NO

VACCINE SCREENING

Have you received an influenza vaccine for the current year? ☐ YES ☐ NO

If yes, what was the date of your last flu vaccine? _____

If no, are you interested in receiving a flu vaccine today? ☐ YES ☐ NO

Have you ever received a pneumococcal vaccine? ☐ YES ☐ NO

If applicable, which pneumococcal vaccine did you receive?

Prevnar 13 **Prevnar 23** **Prevnar 20**

If applicable, what was the date of your last pneumococcal vaccine? _____

If applicable, are you interested in receiving a pneumococcal vaccine today? ☐ YES ☐ NO

Have you ever received a Shingrix vaccine? *If yes, when:* _____ ☐ YES ☐ NO

OSTEOPOROSIS SCREENING

If you have had a bone density scan, what was the date of your last bone density screening? _____

If applicable, what was the result of your last bone density scan?

Normal **Osteoporosis** **Osteopenia** **Unknown**

PROSTATE CANCER SCREENING

If you have had a PSA screening, what was the date of your last PSA screening? _____

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ANNUAL WELLNESS VISITS

BILLING NOTICE & CONSENT

PHONE
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HOW YOUR WELLNESS VISIT IS BILLED

When you are in for your yearly preventive visit, your insurance company will be billed for a **PREVENTIVE EXAM**, which is covered by most insurances at 100%. During your **PREVENTIVE EXAM**, if other problems are discussed with the provider — such as elevated blood pressure, cholesterol issues, diabetes, or any other illnesses — your insurance company will also be billed for a **REGULAR OFFICE VISIT**, which could go towards your co-pay or deductible.

These billing procedures are not dictated by this office but by government agencies which structure correct coding. If you have any questions, please contact our billing department.

PRINT NAME _____ SIGNATURE _____ DATE _____

ARTIFICIAL INTELLIGENCE USE NOTIFICATION

Our office uses artificial intelligence (AI) to help document your visit, which includes a secure voice software system that securely records and transcribes the patient/provider discussion. Your privacy is protected and the system is **HIPAA compliant**. Recordings are transcribed directly into your chart and are not part of the public internet. Only BIMGA can access these records.

✎ By initialing here _____ you consent to **AI use by your provider** during today's visit documentation.

BIMGA
BEAUMONT INTERNAL MEDICINE & GERIATRIC ASSOCIATES

AUTHORIZATION TO RELEASE

HEALTHCARE INFORMATION

PHONE
(409) 898-2994
FAX
(409) 899-5542
EMAIL
Medicalrecords@bimga.com

PATIENT INFORMATION

PATIENT'S FULL NAME

DATE OF BIRTH

SOCIAL SECURITY #

PATIENT'S PHONE #

STREET ADDRESS

CITY

STATE

ZIP

AUTHORIZATION DIRECTION — CIRCLE ONE

○ **Release My Information TO the following**
Send my records to the provider listed below

○ **Release My Information FROM the following**
Receive records from the provider listed below

HEALTHCARE PROVIDER OR FACILITY

NAME OF PROVIDER / FACILITY

STREET ADDRESS

CITY

STATE

PHONE

FAX

INFORMATION TO BE DISCLOSED

Physician Notes	☐ YES	☐ NO	**X-Ray / Diagnostic Imaging Reports**	☐ YES	☐ NO
Lab Results	☐ YES	☐ NO	**Complete Record**	☐ YES	☐ NO
Cardiac Studies	☐ YES	☐ NO	**Pulmonary Studies**	☐ YES	☐ NO
Other: _____	☐ YES	☐ NO			

I understand my medical record may contain reports, test results, and notes that only a physician can interpret. I should not contact my physician solely regarding entries in my record to prevent misunderstanding. I will not hold **Beaumont Internal Medicine & Geriatric Associates** liable for any misinterpretation resulting from not consulting my physician.

I understand this record may include information relating to sexually transmitted diseases, acquired immunodeficiency (HIV), behavioral or mental health services, or treatment for alcohol & drug abuse.

Right to Revoke: I have the right to revoke this authorization at any time in writing. Revocation will not apply to information already released. **Other Rights:** I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: By initialing here _____ I certify this authorization will remain **valid indefinitely** unless revoked in writing. If I choose *not* to initial, this authorization will **expire in six (6) months** from the date signed below.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

RELATIONSHIP (IF REPRESENTATIVE)

DATE SIGNED

BIMGA
BEAUMONT INTERNAL MEDICINE & GERIATRIC ASSOCIATES

AUTHORIZATION TO RELEASE

MEDICAL INFORMATION (HIPAA)

PHONE
(409) 898-2994
FAX
(409) 899-5542
EMAIL
Medicalrecords@bimga.com

I, ______________ (**patient name**), give permission to **Beaumont Internal Medicine & Geriatric Associates** to discuss any of my medical information with the following individuals:

NAME ______________ **PHONE** ______________
EMAIL ______________
RELATIONSHIP: Spouse • Parent • Child • Grandchild • Caregiver • Friend • POA/Guardian • Other: ____________

NAME ______________ **PHONE** ______________
EMAIL ______________
RELATIONSHIP: Spouse • Parent • Child • Grandchild • Caregiver • Friend • POA/Guardian • Other: ____________

NAME ______________ **PHONE** ______________
EMAIL ______________
RELATIONSHIP: Spouse • Parent • Child • Grandchild • Caregiver • Friend • POA/Guardian • Other: ____________

NAME ______________ **PHONE** ______________
EMAIL ______________
RELATIONSHIP: Spouse • Parent • Child • Grandchild • Caregiver • Friend • POA/Guardian • Other: ____________

Expiration: By initialing here ______________ I certify this authorization will remain **valid indefinitely** unless revoked by me in writing. I understand that if I choose not to initial here, this authorization will **expire in one (1) year**. You may revoke this authorization at any time by submitting a written request to our office.

PATIENT SIGNATURE ______________ **DOB** ______________ **DATE** ______________