

MEDICARE WELLNESS VISIT

Your preventive visit will assess the following:

- ∞ your medical and surgical history
- ∞ your current medications
- ∞ your relevant family history
- ∞ your use of any alcohol, tobacco, or illicit drugs
- ∞ your current physical activity
- ∞ any other providers/suppliers involved in your care
- ∞ any depression, cognitive impairment, or safety concerns
- ∞ an exam of your height, weight, body mass index and blood pressure
- any "end of life" planning concerns

The visit concludes with the following:

- ∞ development of a list of any identified preventive health concerns
- ∞ education, counseling, and referrals based on any such concerns
- ∞ a personalized written "screening schedule" detailing any recommended screening/preventive services that are covered by Medicare

The visit will not include:

- ∞ Refills of chronic medications or prescription of new medications
- ∞ evaluation of status of chronic diseases such as diabetes, high blood pressure, high cholesterol, heart diseases, arthritis, urinary symptoms, etc.
- ∞ actual performance of a preventive service, such as PAP smear or prostate exam
- ∞ an actual physical exam (such as looking at the skin, listening to the heart and lungs, etc.
- ∞ blood tests to follow any condition the patient is known to have or to diagnose any condition except for a few screening tests Medicare covers

PLEASE NOTE: Per Medicare, this annual Medicare Wellness Visit is intended to be a "wellness" visit, limited to health promotion and disease prevention. To the extent that you and your doctor spend any time during your doctor spend any time during your preventive visit addressing non-preventive issues such as illnesses, diseases, and/or injuries that you may have, Medicare has directed us to code and bill for such services separately and in addition to the preventive visit. We mention this in advance of your exam so that you are aware that you may incur charges for this visit, depending on the extent of the exam and any copays and/or deductibles you may be responsible for through your Medicare coverage.

To get started, please complete the following 4 pages of questions,
to the best of your ability,
IN ADVANCE of your visit with the doctor.



Patient Name:	Date of Birth:
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You have been scheduled for a **Medicare Wellness Visit**. The following information is needed to complete your visit. Please fill in all the information requested. If more space is needed, you may use the back of the forms.

CURRENT MEDICAL PROBLEMS	Active Problems: List any current medical problems or conditions											
PAST MEDICAL HISTORY	Past Medical History: List any previous medical illness, diseases, health problems that no longer need treatment (i.e. childhood illnesses, pneumonia, alcohol abuse, prostate cancer, etc.)											
	Childhood Illness											
	Chronic Illnesses											
FAMILY HISTORY	FAMILY HISTORY	Self	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Sisters	Brothers	Aunts Uncles	Children
	Deceased	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	High Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Thyroid Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Liver Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Mental Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Colorectal Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Prostate Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Breast Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient Healthcare Questionnaire

Please select the best answer:

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More Than Half the Days	Nearly Every Day
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling bad about yourself, or feel like a failure, or have let yourself or your family down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble concentrating on things, such as reading the paper or watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Moving or speaking slowly or being fidgety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoughts that you would be better dead or of hurting yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please select the best answer the following questions:

Are you satisfied with your life? Yes No

Do you feel that your life is empty? 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

Has your hearing decreased? Normal Slightly Decreased Significantly Decreased

Do you use a hearing aid? Yes No

Do you need help with any of the following activities?

- Using the Phone
 Transportation
 Shopping
 Preparing Meals
 Doing Housework
 Doing Laundry
 Managing Medications
 Managing Money

Do you have any of the following risks for fall?

- Multiple Medications
 Alcohol Use
 Mobility Impairment
 Antidepressant Use
 Weaknesses
 Positional Hypotension
 Sedative Use
 Visual Impairment
 Urinary Incontinence
 High Blood Pressure Medication
 Cognitive Impairment
 Unsteady
 Previous Fall

Do you have any of the following home safety risk factors?

- Unfamiliar Surroundings
 Loose Rugs
 Poor Household Lighting
 Uneven Floors
 Household Clutter
 No Grab Bars in Bathroom
 No Handrails on Stairs

Please select the best answer for the following:

Bathing - either sponge bath, tub bath, or shower

- Receives no assistance (gets in and out of tub/shower by self)
- Receives assistance in bathing only one part of the body (such as back or a leg)
- Receives assistance in bathing more than one part of the body (or not bathed)

Dressing - gets cloths from closet and drawers - including underclothes, outer garments, and using fasteners

- Gets clothes and gets completely dressed without assistance
- Gets clothes and gets dressed without assistance except for assistance in tying shoes
- Receives assistance getting clothes or getting dressed, or stays partly or completely undressed

Toileting - going to the "toilet room" for bowel or urine elimination, cleaning self after , and arranging clothes

- Goes to the bathroom, cleans self, arranges clothes without assistance
- Receives assistance in the bathroom or in cleaning self or arranging clothes after elimination
- Doesn't go to room termed "toilet" for elimination process

Transfer

- Moves in and out of bed/chair without assistance (may use cane or walker)
- Moves in and out of bed/chair with assistance
- Doesn't get out of bed

Continence

- Controls urination and bowel movement completely by self
- Has occasional "accidents"
- Supervision helps keep urine/bowel control, catheter is used, or is incontinent

Feeding

- Feeds self without assistance
- Feeds self except for getting assistance in cutting meat or buttering bread
- Receives assistance in feeding or is fed partly or completely by tubes/intravenous fluids

Do you have an Advanced Directive? Yes No Living Will? Yes No

Do you have a Durable Power of Attorney for Healthcare? Yes No

Please bring these completed forms with you to your Medicare Wellness Visit.

Thank you !

