MEDICARE'S PREVENTIVE CARE COVERAGE

Medicare now covers 2 types of "physicals" – one when you are new to Medicare Part B known as the "Welcome to Medicare" exam, and the other called the "Annual Wellness Exam". The term "physical" is often used to describe wellness care, but Medicare does not pay for a traditional, head-to-toe physical; it *does* pay for a wellness visit once a year to identify health risks and help you to reduce them.

ONE-TIME "WELCOME TO MEDICARE" VISIT:

Medicare covers ONE of these appointments, but it must be scheduled during the first 12 months of your Medicare eligibility. It includes:

- Screenings to detect depression, risk for falling, and other problems,
- A limited physical exam to check your blood pressure, weight, vision, and other things depending on your age, gender and level of activity,
- Recommendations for other wellness services and healthy lifestyle changes.

"ANNUAL WELLNESS EXAM":

After you have had Medicare Part B for more than 12 months, you can get a yearly wellness visit to develop or update a prevention plan based on your current health and risk factors; this exam is covered once every 12 months (You do not need to have the "Welcome to Medicare" visit before getting your annual exam, but it may not be done less than 12 months after your "Welcome to Medicare" visit). This visit covers similar things to the Welcome to Medicare visit.

A Wellness Visit does not deal with new or existing health problems; that would be a separate service and requires a longer appointment. Please let our scheduling staff know if you need the doctor's help with a health problem or something else - we may need to schedule a separate appointment. ***A separate charge applies to that service, whether provided on the same date or a different date than the Wellness Visit.***

Medicare has a lot of requirements for these 2 exams, and we therefore ask you to please fill out the enclosed forms completely before your appointment, and bring the forms with you. We are **required by Medicare** to obtain this information for documentation of your visit, and we apologize for the inconvenience, *but if you do not bring in these completed forms at the time of your appointment, we will have to reschedule your appointment.*

Your appointment date and time: _____

MEDICARE "WELLNESS" EXAM QUESTIONNAIRE

NAME: _____ BIRTHDATE: _____

IMMUNIZATIONS: **DATE OF LAST IMMUNIZATIONS (if known):**

Flu shot _____
Pneumovax _____
Zostavax/"Shingles shot" _____
Tetanus/Tdap _____

FAMILY HISTORY:	**Father**	**Mother**	**Siblings**	**Children**	**Comments**
Heart disease	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Epilepsy/convulsions	_____	_____	_____	_____	_____
Bleeding disorder	_____	_____	_____	_____	_____
Kidney disease	_____	_____	_____	_____	_____
Thyroid disease	_____	_____	_____	_____	_____
Mental illness	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____
Living	_____	_____	_____	_____	_____
Deceased (at what age?)	_____	_____	_____	_____	_____

MARITAL STATUS: Married_____ Single _____ Widowed _____ Divorced_____
Are you sexually active? ____yes ____no; Who else lives at home with you?_____

SMOKING: Do you or have you smoked in the past? ____yes ____no; if yes, how much? _____

ALCOHOL: Do you drink alcohol? ____yes ____no; if yes, how many drinks per week? _____

EXERCISE: Do you participate in a regular exercise routine? (walking, weights, gym) ____yes ____no
How often do you exercise, and for how long each time? _____
What type of exercise do you do?_____

SLEEP: Do you have difficulty falling asleep? ____yes ____no
Difficulty staying asleep? ____yes ____no; Daytime drowsiness? ____yes ____no
Loud snoring? ____yes ____no; How many hours do you sleep per night (average)? _____

ADVANCE DIRECTIVE:

Do you have an Advance Directive for Healthcare? ____yes ____no (if yes, please bring a copy)
Have you discussed your wishes for your future healthcare with your family? ____yes ____no

DO YOU SEE ANY OTHER HEALTH CARE PROVIDERS (including specialists)?

Dentist: Name_____ City_____ How often?_____

Eye Doctor: Name_____ City_____ How often?_____

Podiatrist: Name_____ City_____ How often?_____

Other: Name_____ City_____ How often?_____

Name_____ City_____ How often?_____

Name_____ City_____ How often?_____

PHARMACY: (1)_____Phone or fax #_____
(2)_____Phone or fax #_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? If so, which ones and what kind of reaction did you have to it/them?

_____
_____

MEDICATIONS LIST: Please list all medications you take on a regular basis, including over the counter (non-prescription) medications, vitamins, herbal medications, supplements, and medications prescribed by other doctors:

Medication:	**Strength (mg)**	**Dose (how many & how often)**

Safety & Fall Risk Assessment Questionnaire

Circle one:

1. Have you fallen in the past 6 months?.....YES NO
2. If you answered YES to question # 1, were you injured?.....YES NO
3. Have you experienced urgency or frequency of urination in the past 6 months?.....YES NO
4. Have you had episodes of dizziness in the past 6 months?..... YES NO
5. Do you use any aids for getting around?.....YES NO
6. If you answered YES to question # 5 circle which aid you use:

   (a) another person, (b) railings, (c) cane, (d) walker, (e) wheelchair
7. Do you grab bars in your bathtub/shower? Do you need them?.....YES NO
8. Do you have working smoke detectors in your home?.....YES NO
9. Do you sometimes forget to buckle your seatbelt when traveling in a car?.....YES NO
10. Does your home have a fireplace?.....YES NO
11. Do you have guns in your home?.....YES NO
12. Do you use supplemental oxygen on a regular basis?.....YES NO
13. Do you have fire extinguishers in your home?.....YES NO
14. Do you have stairs in your home?.....YES NO
15. Do you use scatter/throw rugs in your home?.....YES NO
16. Do you have pets in your home?.....YES NO
17. Does your home have a pool or hot tub?.....YES NO
18. Do you have any problems with your hearing?.....YES NO
19. Do you have vision problems that cause safety problems at home?.....YES NO

Activities of Daily Living Questionnaire

Information obtained from patient_____ Information obtained from other person_____/who?_____

Circle the most appropriate answer in each category:

Using a Telephone	**I =** Able to look up phone numbers, dial receive and make calls without help **A** =Able to answer phone or dial operator in an emergency, but needs special phone or help in getting number & dialing **D**= Unable to use telephone
Traveling	**I** = Able to drive own car or travel alone on buses, taxis **A**= Able to travel but needs someone to travel with **D**= Unable to travel
Shopping	**I** = Able to take care of all food/clothing needs **A**= Able to shop but needs someone to shop with **D**= Unable to shop
Preparing Meals	**I** = Able to plan and cook full meals **A**= Able to prepare light foods but unable to cook full meals alone **D**= Unable to prepare any meals
Housework	**I** = Able to do heavy housework (e.g., vacuum, scrub floors) **A=**Able to do light housework but needs help with heavy tasks **D**=Unable to do any housework
Taking Medicines	**I** = Able to prepare & take medications in the right dose at the right time **A**=Able to take medications, but needs reminding or someone to prepare them **D**=Unable to manage/take medications
Managing Money	**I**= Able to manage buying needs(e.g., write checks, pay bills) **A**=Able to manage daily buying needs but needs help managing checkbook, paying bills **D**=Unable to manage money
Bathing	**I**= Able to shower/bathe without assistance **A**=Able to shower/bathe with some help **D**=Unable to shower/bathe without extensive help
Toileting	**I**= Able to get, onto and off of toilet without assistance or accidents **A**=Needs help getting on/off toilet **D**=Unable to use toilet even with assistance
Getting Dressed	**I**= Able to choose clothing appropriate to situation and weather and dress completely without help **A**=Able to dress self but needs help choosing clothing **D**=Unable to put clothing on without help
Getting around in the home	**I**= Able to maneuver around the house without assistance **A**=Can transfer from bed/chair to wheelchair but needs assistance **D**=Unable to transfer without maximum assistance

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Reviewed by:_____ Date:_____