Dear _____,

***Your Appointment for the ☐ Welcome to Medicare Visit OR ☐ Annual Wellness Visit is scheduled* on._____ *at* ___**

***There is NO CO-PAY** for this visit, so it is free for you.*

The goal of this visit is to provide time for you to discuss with your doctor, areas of your health that may put you at risk for problems in the future.

As part of the visit, you will be screened for fall risk, safety risk, worsening memory, depression and other medical concerns.

***This is NOT a "full physical",** but a time to review your medical history and make certain that appropriate screening tests have been performed.*

*This visit **WILL NOT** include treatment or management of problems.*

Examples of things not covered in the Annual Wellness Visit are:

- *Refills of chronic medications or prescription of new medications*
- *Evaluation of status of chronic diseases such as diabetes, high blood pressure, high cholesterol, heart disease, arthritis, urinary symptoms*
- *An actual physical exam (such as looking at the skin, listening to the heart and lungs, examining the abdomen)*
- *Blood tests to follow any condition you are known to have.*

*In order to help the visit run smoothly, please complete the **enclosed forms and bring them with you to your visit.** Try to complete as much as you can before your appointment. The information will help you and your doctor better understand what screenings you should get and what to watch for in the future.*

If you arrive at the office without these forms, your visit may need to be rescheduled.

Please make sure to be on time and call with more than 24 hours' notice if you cannot make your appointment.

If you have questions regarding this visit, please speak with your doctor.

We look forward to seeing you soon.

MEDICARE WELLNESS VISIT

Please complete this questionnaire as thoroughly as possible. This confidential history will be part ofyour permanent records and will help us get a better understanding ofyour overall health. THANK YOU!

NAME:_____ AGE:_____ DOB:_____ Today's date:_____

Social History ✓ all that apply:

Tobacco Use: ☐ Cigarettes ☐ Chew ☐ Cigars ☐ Snuff ☐ 2nd hand ☐ Never ☐ Prior use **Quit Date: _____**

Frequency: cigs/packs day/week # of yrs: _____

Are you interested in quitting? ☐ Yes ☐ No

Alcohol:_____ ☐ Never ☐ Occasional ☐ Daily

Caffeine: _____ ☐ Never ☐ Occasional ☐ Daily

Drugs: _____ ☐ Never ☐ Occasional ☐ Daily ☐ Prior **Quit Date:_____**

Occupation:_____ **Exercise:** (type/frequency)_____

Home Environment: ☐ Private home ☐ Assisted living ☐ Other: (describe)

Family History - use ✓ to indicate positive history

	Self	Father	Mother	Brothers	Sisters	Aunts	Uncles	Daughters	Sons
Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Deoression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐

NAME:_____

PATIENT SECTION

Have you had any hospital visits? ☐NO ☐YES If yes:

Reason	Date	Where

Have you had any Past Surgeries? ☐NO ☐YES *If yes:*

Type/Reason	Date	Where

Have you have any allergies? ☐NO ☐YES *If yes:*

Allergy to what?	What type of reaction?

Please list all of your current medications, including VITAMINS, HERBS, OVER THE COUNTER MEDICATIONS and SUPPLEMENTS

MEDICATION OR SUPPLEMENT	DOSE, HOW MANY TIMES A DAY	MEDICATION OR SUPPLEMENT	DOSE, HOW MANY TIMES A DAY

➔**Have you discussed taking a daily aspirin with your doctor?** ☐ Yes ☐ No

NAME:_____

PATIENT SECTION

Please list any Chronic Medical Problems:

MEDICAL CONDITION	DOCTOR WHO MANAGES	YEAR DIAGNOSED

Please list any Acute or New Medical problems:

MEDICAL CONDITION	DOCTOR WHO MANAGES	How long has this been going on?

Please list all other providers that you see; please include therapists, chiropractors, acupuncturists, nutritionists, etc:

PROVIDER'S NAME	What do you see them for?

NAME:_____

PATIENT SECTION

HEARING SCREENING:

	Yes	No
Do you have a problem hearing the telephone?	☐	☐
Do you have trouble hearing the television or radio?	☐	☐
Do people complain that you turn the TV volume up too high?	☐	☐
Do you have to strain to understand conversatIon?	☐	☐
Do you find yourself asking people to repeat themselves?	☐	☐
Do many people you talk to seem to mumble (or not speak clearly)?	☐	☐

BALANCE/SAFETY/FALL SCREENING:

	Yes	No	Sometimes
Do you live alone?	☐	☐	☐
Does your home have rugs in the hallway?	☐	☐	☐
Do you need help with the phone, transportation, shopping, meals, housework, laundry? Does	☐	☐	☐
your home LACK grab bars in bathrooms, handrails on stairs and steps?	☐	☐	☐
Does your home LACK functioning smoke alarms?	☐	☐	☐
Does bending over increase dizziness, or imbalance?	☐	☐	☐
Do you restrict travel for business/recreation due to your imbalance?	☐	☐	☐
Are you afraid to 'leave the house alone due to dizziness or imbalance problems?	☐	☐	☐
Have you fallen in the past year?	☐	☐	☐

EXERCISE

How many days a week do you usually exercise?_____ days per week

On days when you exercise, for how long do you usually exercise? _____minutes per day ☐Does not apply

How intense is your typical exercise? (check one) ☐ I'm currently not exercising ☐ **Light** (like stretching or slow walking)

☐ **Moderate** (like brisk walking) ☐ **Heavy** (like jogging or swimming) ☐ **Very Heavy** (like fast running or stair climbing)

NUTRITION

Are you on a special diet? □ Yes □ No *If yes, why?*

On a typical day, how many servings of fruits and/or vegetables do you eat? ___ servings per day

(1 serving= 1 cup of fresh vegetables,½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup= size of a baseball)

On a typical day, how many servings of high fiber or whole grain foods do you eat? ____ servings per day

(1 serving= 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal.

½ cup of cooked cereal such as ,oatmeal, or ½ cup of cooked brown rice or whole wheat pasta)

On a typical day, how many servings of fried or high fat foods do you eat? ____ servings per day

(Examples include fried chicken, fried fish, bacon, French fries., potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise)

MOTOR VEHICLE SAFETY

Do you always fasten your seat belt when you are in the car? ☐Yes ☐No

Do you ever drive after drinking , or ride with a driver who has been drinking? ☐Yes ☐No

SUN EXPOSURE

Do you protect yourself from the sun when you are outdoors? ☐Yes ☐No

NAME:_____

PATIENT SECTION

GENERAL WELL-BEING

How often is stress a problem for ou?
How well do you handle the stress in your life?

Never/rarely	Sometimes	Often	Always
☐	☐	☐	☐
I'm usually able to cope effectively	At times I have problems coping	I often have problems coping	

How many hours of sleep do you usually get each night?_____

In general, would you say your health is:	**Excellent**	**Very good**	**Good**	**Fair**	**Poor**
	☐	☐	☐	☐	☐
How often do you get the social and emotional support you need:	**Always**	**Usually**	**Sometimes**	**Rarely**	**Never**
	☐	☐	☐	☐	☐
In general, how satisfied are you with your life:	**Very satisfied**	**Satisfied**	**Dissatisfied**	**Very dissatisfied**	
	☐	☐	☐	☐	

DEPRESSION SCREENING: PHQ-9

Over the last 2 WEEKS how often have you been bothered by any of the following:

(check the appropriate box to the right)

	(0) Not at all	**(1) Several Days**	**(2) More than half the days**	**(3) Nearly eyery day**
1. Little interest or pleasure in doing things.	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
3. Trouble falling/staying asleep, sleep too much.	☐	☐	☐	☐
4. Feeling tired or having little energy.	☐	☐	☐	☐
5. Poor appetite or overeating.	☐	☐	☐	☐
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
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.	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

A. 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 difficuit

B. In the past two years have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

Physician/Provider signature: _____