UNIVERSAL MEDICINE

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**Preventative Visit and Annual Wellness Exam A "Welcome to Medicare" preventive visit:** You can get this introductory visit only within the first 12 months you have Part B. This visit includes a review of your medical and social history related to your health and education and counseling about preventive services, including:

- Certain screenings, shots, and referrals for other care, if needed
- Height, weight, and blood pressure measurements
- A calculation of your body mass index
- A simple vision test
- A review of your potential risk for depression and your level of safety
- An offer to talk with you about creating advance directives
- A written plan letting you know which screenings, shots, and other preventive services you need

***This visit is covered one time. You don't need to have this visit to be covered for yearly "Wellness" visits.***

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**Yearly "Wellness" visits:** If you've had Part B for longer than 12 months, you can get this visit to develop or update a personalized prevention help plan. This plan is designed to help prevent disease and disability based on your current health and risk factors. Your provider will ask you to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit. It can also include:

- A review of your medical and family history
- Developing or updating a list of current providers and prescriptions
- Height, weight, blood pressure, and other routine measurements
- Detection of any cognitive impairment
- Personalized health advice
- A list of risk factors and treatment options for you
- A screening schedule (like a checklist) for appropriate preventive services. Get details about coverage for screenings, shots, and other preventive services
- Advance Care Planning

***This visit is covered once every 12 months (11 full months must have passed since the last visit). Note: You pay nothing for the "Welcome to Medicare" preventive visit or the yearly "Wellness" visit. However, if your doctor or other health care provider performs additional tests or services during the same visit that aren't covered under these preventive benefits, you will have to pay copay, and the Part B deductible will apply.***

## MEDICAL ANNUAL HEALTH RISK ASSESSMENT QUESTIONAIRE

Name: _____ Date: _____

Age: _____ Marital Status: _____

Language Spoken: _____ Interpreter Needed? _____

Gender: _____

Please list the names of your subspecialists and what they treat you for:

| Subspecialist Name | Condition |
|---|---|
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Please list the date of your last preventative appointment/s for the following:

**Mammogram:** _____
**Colonoscopy:** _____
**Endoscopy:** _____
**DEXA:** _____

Please list the date of your last vaccination for the following:

**Pneumonia:** _____
**PCV13:** _____
**Shingles:** _____
**Tdap:** _____
**Flu:** _____
**Covid:** _____

## CURRENT HEALTH STATUS

1. In general, would you say your health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. How confident are you that you can control and manage your health problems?
   - ○ Very confident
   - ○ Somewhat confident
   - ○ Not very confident
   - ○ I do not have any health problems

3. Were you hospitalized in the Emergency Department, or had surgery within the last 12 months?
   - ○ Yes
   - ○ No

4. In the past 7 days, how much pain have you felt?
   - ○ No pain
   - ○ Very mild pain
   - ○ Mild pain
   - ○ Moderate pain
   - ○ Severe pain

5. Do you have any tooth, denture, or oral problems?
   - ○ Yes
   - ○ No

6. How many hours of sleep do you usually get each night?
   - ○ < 4 hours
   - ○ 5-6 hours
   - ○ 6-8 hours
   - ○ > 9 hours

7. Do you snore or has anyone informed you that you snore?
   - ○ Yes
   - ○ No

8. In the past 7 days, how often have you felt sleepy during the day?
   - ○ Always
   - ○ Usually
   - ○ Sometimes
   - ○ Rarely
   - ○ Never

## LIVING STATUS

9. What is your current living situation?
    - ○ Live alone
    - ○ Live with spouse
    - ○ Live with significant other
    - ○ Live with relatives
    - ○ Live with friend
    - ○ Live in a nursing home
    - ○ Live in assisted living
    - ○ Homeless
    - ○ Live with a caregiver

10. In a typical week, how many times do you get together or talk on the phone with family and/or friends?
    - ○ Never
    - ○ Once a week
    - ○ 2 times a week
    - ○ 3 times a week
    - ○ More than 3 times a week

## COPING WITH STRESS, DEPRESSION & ANXIETY

11. How often is stress a problem with you in handling your health?
    - ○ Never or rarely
    - ○ Sometimes
    - ○ Often
    - ○ Always

12. How often is stress a problem with you in handling your finances?
    - ○ Never or rarely
    - ○ Sometimes
    - ○ Often
    - ○ Always

13. How often is stress a problem for you in handling your family or social relationships?
    - ○ Never or rarely
    - ○ Sometimes
    - ○ Often
    - ○ Always

14. How often is stress a problem for you in handling your work?
    - ○ Never or rarely
    - ○ Sometimes
    - ○ Often
    - ○ Always

15. Are you able to manage your feelings of anger well?
    - ○ Yes
    - ○ No

16. Over the past month, how often have you been bothered by any of the following problems?
    a. Little interest or pleasure in doing things
        - ○ Not at all
        - ○ Several days
        - ○ More than half the days
        - ○ Nearly every day

    b. Feeling tired or having little energy
        - ○ Not at all
        - ○ Several days
        - ○ More than half the days
        - ○ Nearly every day

    c. Poor appetite or overeating
        - ○ Not at all
        - ○ Several days
        - ○ More than half the days
        - ○ Nearly every day

    d. Feeling bad about yourself or that you are a failure
        - ○ Not at all
        - ○ Several days
        - ○ More than half the days
        - ○ Nearly every day

    e. Trouble concentrating on things, such as reading or watching the television
        - ○ Not at all
        - ○ Several days
        - ○ More than half the days
        - ○ Nearly every day

    f. Feeling down, depressed, or hopeless
        - ○ Not at all
        - ○ Several days
        - ○ More than half the days
        - ○ Nearly every day

    g. Trouble falling or staying asleep, or sleeping too much
        - ○ Not at all
        - ○ Several days
        - ○ More than half the days
        - ○ Nearly every day

h. If you have checked off any problems, how difficult have these issues made it for you to do your work, take care of things at home, or get along with others
   - ○ Not difficult at all
   - ○ Somewhat difficult
   - ○ Very difficult
   - ○ Extremely difficult

17. Over the last month, how often were you bothered by any of the following problems?
    a. Feeling nervous, anxious, or on edge
       - ○ Not at all
       - ○ Several days
       - ○ More than half the days
       - ○ Nearly every day

    b. Not being able to stop or control worrying
       - ○ Not at all
       - ○ Several days
       - ○ More than half the days
       - ○ Nearly every day

## SMOKING & ALCOHOL ASSESSMENT

18. In the last month, have you smoked tobacco, cigars, pipes, or cigarettes?
    - ○ Yes
    - ○ No

19. If you smoke or use smokeless tobacco, would you be interested in quitting within the next month?
    - ○ Yes
    - ○ No

20. In the past 7 days, how many of them did you drink alcohol?
    - ○ None
    - ○ 1-2 days
    - ○ 3-4 days
    - ○ 5-7 days

## EXERCISE & NUTRITION ASSESSMENT

21. Do you consume fruits and vegetables on a daily basis?
    - ○ Yes
    - ○ No

22. Do you consume whole grain foods on a daily basis?
    - ○ Yes
    - ○ No

23. Do you consume fried or high-fat foods on a daily basis?
    - ○ Yes
    - ○ No

24. How many hours of exercise, including walking, do you do every day?
    - ○ None
    - ○ 20-30 minutes
    - ○ 1 hour
    - ○ 1-2 hours

25. How intense is your typical exercise?
    - ○ Light
    - ○ Moderate
    - ○ Heavy
    - ○ Very Heavy
    - ○ I am currently not exercising

## FUNCTIONAL ASSESSMENT

26. In the past month, did you require assistance from others to perform any of the following everyday activities?
    - ○ Bathing
    - ○ Dressing
    - ○ Grooming
    - ○ Eating
    - ○ Walking
    - ○ Using the toilet
    - ○ None of the above

27. In the past month, did you require assistance from others to take care of any of the following chores?
    - ○ Laundry
    - ○ Housekeeping
    - ○ Cooking
    - ○ Shopping
    - ○ Transportation
    - ○ Managing finances
    - ○ Managing medications
    - ○ Using the telephone
    - ○ None of the above

## FALL ASSESSMENT

28. Have you fallen two or more times within the past year?
    - ○ Yes
    - ○ No

29. Do you feel unsteady when you walk?
    - ○ Yes
    - ○ No

30. What assistive device/s do you use?
    - ○ Bath bar/seat
    - ○ Cane
    - ○ Walker
    - ○ Wheelchair
    - ○ None

## HEARING ASSESSMENT

31. Do you struggle to hear or understand conversations?
    - ○ Yes
    - ○ No

32. Do you have trouble hearing the television or radio when others do not?
    - ○ Yes
    - ○ No

## COGNITIVE RISK ASSESSMENT

33. Do you have trouble remembering or recalling facts or events?
    - ○ Yes
    - ○ No

34. Do family members or caregivers report that you have difficulty remembering things?
    - ○ Yes
    - ○ No

## END OF LIFE PLANNING

35. Do you have an updated/current Living Will and Power or Attorney for healthcare or a legal guardian?
    - ○ Yes
    - ○ No