

**377 Macktown Road Sylva, NC 28779 Office: (828)586-6262 Fax: (828)412-4294**

MDC annual consent

Especially as we age, one of the more important things that we can do to maintain quality of life is to make excellent plans to maintain a sound body and mind. We would like to offer you that service, especially in light of the hard work that you have done to get to retirement. Please read the following and initial and sign where indicated.

\_\_\_\_\_ I understand that Medicare and any additional supplements do not reimburse Dogwood Wellness for the expense of the half hour visit that we prefer to offer you.

\_\_\_\_\_ I understand that the Medicare annual is reimbursed at a level that helps to support our ability to offer you these longer visits.

\_\_\_\_\_ To be a patient with Dogwood Wellness, I voluntarily agree to do the Medicare annual every year and I understand that this enables Dogwood Wellness to offer me prolonged visits at any other time.

\_\_\_\_\_ I understand that the basic annual is completely covered by Medicare. Additional charges may apply if there are medical problems to be discussed or prescription needs. This additional charge is also required by Medicare because the annual only covers the basic screening and safety requirements.

Thank you for your understanding and your support of our ability to be able to continue to accept Medicare patients in our practice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ written name

**MEDICARE WELLNESS CHECKUP**

Please circle the answer that applies best to you. Your responses will help you receive the best health and health care possible.

1. What is your age:

65-69. 70-79. 80 or older.

1. Are you a male or a female?

Male. Female.

1. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

Not at all.

Slightly.

Moderately.

Quite a bit.

Extremely.

1. During the **past four weeks**, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

Not at all.

Slightly.

Moderately.

Quite a bit.

Extremely.

1. During the **past four weeks**, how much bodily pain have you generally had?

No pain.

Very mild pain.

Mild pain.

Moderate pain.

Severe pain.

1. During the **past four weeks**, was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

Yes, as much as I wanted.

Yes, quite a bit.

Yes, some.

Yes, a little.

No, not at all.

1. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

Very heavy.

Heavy.

Moderate.

Light.

Very light.

1. Can you get to places out of walking distance without help?

(For example, can you travel alone on buses or taxis, or drive your own car?)

Yes. No.

1. Can you go shopping for groceries or clothes without someone’s help?

Yes. No.

1. Can you prepare your own meals?

Yes. No.

1. Can you do your housework without help?

Yes. No.

1. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, or getting around the house?

Yes. No.

1. Can you handle your own money without help?

Yes. No.

1. During the **past four weeks**, how would you rate your health in general?

Excellent.

Very good.

Good.

Fair.

Poor

1. How have things been going for you during the **past four weeks**?

Very well; could hardly be better.

Pretty well.

Good and bad parts about equal.

Pretty bad.

Very bad; could hardly be worse.

1. Are you having difficulties driving your car?

Yes, often.

Sometimes.

No.

Not applicable, I do not use a car.

1. Do you always fasten your seat belt when you are in a car?

Yes, usually.

Yes, sometimes.

No.

1. How often during the past four weeks have you been bothered by any of the following problems?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Seldom | Sometimes | Often | Always |
| Falling or dizzy when standing up. |  |  |  |  |  |
| Sexual problems. |  |  |  |  |  |
| Trouble eating well. |  |  |  |  |  |
| Teeth or denture problems. |  |  |  |  |  |
| Problems using the telephone. |  |  |  |  |  |
| Tiredness or fatigue. |  |  |  |  |  |

1. Have you fallen two of more times in the **past year**?

Yes. No.

1. Are you afraid of falling?

Yes. No.

1. Are you a smoker?

No.

Yes, and I might quit.

Yes, but I’m not ready to quit.

1. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?

10 or more drinks per week.

6-9 drinks per week.

2-5 drinks per week.

One drink or less per week.

No alcohol at all.

1. Do you exercise for about 20 minutes three or more days a week?

Yes, most of the time.

Yes, some of the time.

No, I usually do not exercise this much

1. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

Yes. No.

Keeping track of your medications?

Yes. No.

1. How often do you have trouble taking medicines the way you have been told to take them?

I do not have to take medicine.

I always take them as prescribed.

Sometimes I take them as prescribed.

I seldom take them as prescribed.

1. How confident are you that you can control and manage most of your health problems?

Very confident.

Somewhat confident.

Not very confident.

I do not have any health problems.

1. What is you race? (**Check all that apply**.)

White.

Black or African American.

Asian.

Native Hawaiian or other Pacific Islander.

American Indian or Alaskan Native.

Hispanic or Latino origin or descent.

Other.

Thank you very much for completing your Medicare Wellness Checkup.

**Medicare Annual Questionnaire**

Please list the names of all your doctors:

|  |  |
| --- | --- |
| **Name** | **Specialty** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Please list all the medications and supplements you currently take:

|  |  |
| --- | --- |
| **Name of medications/supplements** | **Dose (if you remember)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Please answer the following questions by circling Yes or No:

|  |  |  |
| --- | --- | --- |
| Have any of your close relatives had any health changes?  | Yes | No |
| Has your mood changed | Yes | No |
| Are you worried about your memory? | Yes | No |
| Are there any preventive tests you have done recently? (such as lab tests, mammograms, x-rays, etc.) | Yes | No |
| Have you had any recent immunizations? | Yes | No |
| Do you have a living will or advance directive? | Yes | No |

**Geriatric Depression Scale (short form)**

***Instructions:***  Circle the answer that best describes how you felt over the past week.

|  |  |  |
| --- | --- | --- |
| Are you basically satisfied with your life? | Yes | No |
| Have you dropped many of your activities and interest? | Yes | No |
| Do you feel that your life is empty? | Yes | No |
| Do you often get bored? | Yes | No |
| Are you in good spirits most of the time? | 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 |
| Do you feel helpless? | Yes  | No |
| Do you prefer to stay at home, rather than going out and doing things? | Yes | No |
| Do you feel that you have more problems with memory than most? | Yes | No |
| Do you think it is wonderful to be alive now? | Yes | No |
| Do you feel worthless the way you are now? | Yes | No |
| Do you feel full of energy? | Yes  | No |
| Do you feel that your situation is hopeless? | Yes | No |
| Do you think that most people are better off than you are? | Yes | No |

Total Score:\_\_\_\_\_\_\_\_\_\_\_\_

**Katz Index of Independence in Activities of Daily Living**

|  |  |  |
| --- | --- | --- |
| *Question*  | *Independence (1 Points)* | *Dependence (0 Points)* |
| BathingPoints: | Bathes self completely or needs help in bathing only a single part of the body, such as the back, genital area, or disabled extremity | Needs help with bathing more than one part of the body, getting in or out of the bathtub or shower; requires total bathing |
| Dressing Points: | Gets clothes from closets and drawers, and puts on clothes and outer garments complete with fasteners; may need help tying shoes | Needs help with dressing self or needs to be completely dressed |
| Toileting Points: | Goes to toilet, gets on and off, arranges clothes, cleans genital area without help | Needs help transferring to the toilet and cleaning self, or uses bedpan or commode |
| Transferring Points: | Moves in and out of bed or chair unassisted; mechanical transfer aids are acceptable | Needs help in moving from bed to chair or requires a complete transfer |
| Fecal and urinary continence Points: | Exercises complete self-control over urination and defecation | Is partially or totally incontinent of bowel or bladder |
| FeedingPoints: | Gets food from plate into mouth without help; preparation of food may be done by another person | Needs partial or total help with feeding or requires parenteral feeding |

Total Points:\_\_\_\_\_\_\_\_\_\_\_\_

**Nutritional Health Checklist**

|  |  |
| --- | --- |
| *Statement*  | *Yes*  |
| I have an illness or condition that made me change the kind or amount of food I eat. | 2 |
| I eat fewer than two meals per day. | 3 |
| I eat few fruits, vegetables, or milk products. | 2 |
| I have three or more drinks of beer, liquor, or wine almost every day. | 2 |
| I have tooth or mouth problems that make it hard for me to eat. | 2 |
| I don’t always have enough money to buy the food I need. | 4 |
| I eat alone most of the time. | 1 |
| I take three or more different prescription or over-the-counter drugs per day. | 1 |
| Without wanting to, I have lost or gained 10 lb. in the past six months. | 2 |
| I am not always physically able to shop, cook, or feed myself. | 2 |

Total Points:\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: *The Nutritional Health Checklist was developed for the Nutrition Screening Initiative. Read the statements above and circle the number in the “yes” column for each statement that applies to you. Add up the circled numbers to get your nutritional score.*

**Screening version of the Hearing Handicap Inventory for the Elderly**

|  |  |  |  |
| --- | --- | --- | --- |
| *Question*  | *Yes (4 Points)* | *Sometimes (2 Points)* | *No (0 Points)* |
| Does a hearing problem cause you to feel embarrassed when you meet new people? |  |  |  |
| Does a hearing problem cause you to feel frustrated when talking to members of your family? |  |  |  |
| Do you have difficulty hearing when someone speaks in a whisper? |  |  |  |
| Do you feel impaired by a hearing problem? |  |  |  |
| Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors? |  |  |  |
| Does a hearing problem cause you to attend religious services less often than you would like? |  |  |  |
| Does a hearing problem cause you to have arguments with family members? |  |  |  |
| Does a hearing problem cause you difficulty when listening to the television or radio? |  |  |  |
| Do you feel that any difficulty with your hearing limits or hampers your personal or social life? |  |  |  |
| Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? |  |  |  |

Total Points:\_\_\_\_\_\_\_\_\_\_\_\_