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A WORD TO OUR PATIENTS ABOUT MEDICARE AND WELLNESS CARE

Dear patient:

We want you to receive wellness care- health care that may lower your risk of illness or injury. Medicare pays for some wellness care but it does not pay for all of the wellness care you might need. We want you to know about your Medicare benefits and how we can help you get the most from them.

The term “physical” is often used to describe wellness care. However, Medicare does not pay for a traditional head to toe physical. Medicare does pay for a wellness visit once a year to identify health risks and help you to reduce them. We will ask you to complete a questionnaire at your visit.

A wellness visit does not deal with new or existing health problems. That would be a separate service and require another appointment. Please let our scheduling staff know if you need the doctor’s help with a health problem, a medication refill, or something else so that they can schedule a separate appointment. A separate charge applies to these services, whether provided on the same date or different date than the wellness visit.

We hope to help you get the most from your Medicare wellness benefits. Please contact us with any questions.

MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Please fill in all blanks and place check marks where indicated.

Today's date: _____

Name: _____ Date of Birth: _____

Last First Middle

Gender: Male _____ Female: _____

Home phone: _____ Cell Phone: _____

Marital Status: _____ Date of Start of Medicare Part B: _____

Next of Kin for Emergencies (name and phone number): _____

CURRENT MEDICAL PROBLEMS:

List all current medical problems and conditions

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

NAME OF PATIENT: _____

PAST MEDICAL HISTORY:

Please list **childhood illnesses**:

1. _____ 3. _____

2. _____ 4. _____

CHRONIC ILLNESSES: not already mentioned in current medical problems

1. _____ 3. _____

2. _____ 4. _____

DATE OF LAST EYE EXAM/ GLAUCOMA SCREEN: _____

PAST SURGERIES WITH DATES:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

PLEASE LIST ANY OTHER HOSPITAL STAYS:

REASON: _____ DATE: _____

REASON: _____ DATE: _____

REASON: _____ DATE: _____

REASON: _____ DATE: _____

NAME OF PATIENT: _____

SPECIALISTS/PRACTITIONERS YOU CURRENTLY USE:

Name: _____ Speciality: _____

Name: _____ Speciality: _____

Name: _____ Speciality: _____

Name: _____ Speciality: _____

ALLERGIES:

Please list allergies to all medications, foods, x ray dyes, etc.

Please write none if you have no allergies.

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

LIST ALL SUPPLEMENTS AND VITAMINS THAT YOU TAKE:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

NAME OF PATIENT: _____

MEDICATION LIST:

Please list all medications that you take, including over the counter medications like aspirin, ibuprofen, tylenol, etc.

1. Medication: _____ Dose and Directions: _____

Prescribing physician: _____

2. Medication: _____ Dose and Directions: _____

Prescribing physician: _____

3. Medication: _____ Dose and Directions: _____

Prescribing physician: _____

4. Medication: _____ Dose and Directions: _____

Prescribing physician: _____

5. Medication: _____ Dose and Directions: _____

Prescribing physician: _____

6. Medication: _____ Dose and Directions: _____

Prescribing physician: _____

7. Medication: _____ Dose and Directions: _____

Prescribing physician: _____

SOCIAL HISTORY:

Do you drink alcohol/ beer/ wine? Yes ___ No ___ If yes, how much? _____

Are others concerned about your drinking? Yes ___ No ___

NAME OF PATIENT: _____

Diet: Please check if you follow one of these diets:

Vegetarian: ___ Diabetic: ___ Low salt: ___ Low fat: ___ Low carb: ___ Other: ___

Do you do a form of exercise: Yes ___ No ___

If yes, how much and how often? _____

Occupation or Former Occupation: _____

Education: High School: ___ College: ___ Trade school: ___ Graduate School: ___

List everyone in your household including pets:

1. _____ 3. _____

2. _____ 4. _____

Do you wear a seatbelt? Yes ___ No ___

Have you ever smoked or chewed tobacco: Yes ___ No ___

If yes, how much and for how many years? _____

NAME OF PATIENT:

_____

ROUTINE TASKS: Please indicate if you do or do not need help performing these tasks:

1. Feeding yourself: I need help _____ I do not need help _____

2. Getting from bed to chair: I need help _____ I do not need help _____

3. Getting to the toilet: I need help _____ I do not need help _____

4. Getting dressed: I need help _____ I do not need help _____

5. Bathing/ Showering: I need help _____ I do not need help _____

6. Walking across the room: I need help _____ I do not need help _____

7. Using the telephone: I need help _____ I do not need help _____

8. Taking your medications: I need help _____ I do not need help _____

9. Preparing meals: I need help _____ I do not need help _____

10. Managing money (checkbook, bills): I need help _____ I do not need help _____

11. Moderately strenuous housework: I need help _____ I do not need help _____

12. Shopping for personal items: I need help _____ I do not need help _____

13. Shopping for groceries: I need help _____ I do not need help _____

14. Driving: I need help _____ I do not need help _____

15. Climbing a flight of stairs: I need help _____ I do not need help _____

If you need help with any of these activities, who is the one that helps you?

Name: _____ Relation: _____

NAME OF PATIENT: _____

HEARING SCREEN:

Please answer yes, no, or sometimes for each question:

1. Do you find it difficult to follow a conversation in a noisy restaurant or crowded room? Yes ___ No ___ Sometimes ___

2. Do you sometimes feel that people are mumbling or not speaking clearly?

Yes ___ No ___ Sometimes ___

3. Do you find yourself asking people to speak up or repeat themselves?

Yes ___ No ___ Sometimes ___

4. Do you experience difficulty understanding soft or whispered voices?

Yes ___ No ___ Sometimes ___

5. Do you sometimes have difficulty understanding speech on the telephone?

Yes ___ No ___ Sometimes ___

6. Does a hearing problem cause you to visit friends and family less often than you would like?
Yes ___ No ___ Sometimes ___

7. Do you hear better with one ear than the other? Yes ___ No ___ Sometimes ___

8. Have you had any significant noise exposure during work, recreation, or military service?
Yes ___ No ___

9. Have any of your relatives (by birth) had hearing loss? Yes ___ No ___

DEPRESSION SCREENING

Please write your answer in the space provided:

NAME OF PATIENT: _____

1. Do you ever have little interest or pleasure in doing things? If so, how often?

_____

2. Do you ever feel down, depressed, or hopeless? Yes ___ No ___
If yes, how often?

_____

FALLS AND SCREENING: Please place a check for your answer

1. Are you afraid of falling? Yes ___ No ___

2. Have you fallen in the past year? Yes ___ No ___

If you have fallen please circle the circumstances surrounding the fall:

Tripped over something

Lightheadedness or palpitations prior to loss of consciousness/ passing out

Injury occurred

Needed to see a doctor

Able to get up on own

Do you have an Advanced Directive (Living WIll)? Yes ___ No ___

Authorized Signature: _____ Date: _____

Reviewed By: _____ Date: _____

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