Healthcare Partners
Family Medicine

To: Our Medicare Patients
Subject: Medicare Annual Wellness Visit

Beginning January 1, 2011, Medicare covers an "Annual Wellness Visit" in addition to the one-time "Welcome to Medicare" exam. The "Welcome to Medicare" exam occurs only once during your fist twelve months as a Medicare Patient. You may receive your Annual Wellness Visit after you have been with Medicare for more then one year, or it has been at least one year since your "Welcome to Medicare" exam.

The Annual Wellness Visit is not the same thing as what many people often refer to as their yearly physical exam. The hands on physical exam will be the condition management exam. This exam is done on another appointment after having the "Annual Wellness Visit." Medicare is very specific about what the 'Annual Wellness Visit" includes and excludes.

At the Annual Wellness Visit, your doctor will talk to you about your medical history, review you risk factors and make a personalized prevention plan to keep you healthy. The visit does not include a hands-on– exam or any testing that your doctor may recommend, nor does it include any **discussion about any new or current medical problem, condition, medication problems or to refill mediations.** You **must** schedule another visit to address those issues.

You **do not need to fast** since no lab testing is included in this visit. Please remember that"Annual Wellness Visit" does not replace your usually scheduled office visits and is **NOT** an annual physical exam.
Please remember to bring in the completed in full Medicare Annual Wellness Visit Questionnaire form to the day of your scheduled visit.

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Medicare Annual Wellness Visit Questionnaire

PATIENT INFO

Date: _____

Name: _____ _____ _____ Date of Birth: _____
LAST FIRST MIDDLE MM/DD/CCYY

Marital Status: ☐ Married ☐ Single Divorced Widowed Other

Next of Kin *(for emergency)*: _____ Name of spouse : _____

HEALTH MAINTENANCE

Please record the last year you had the following. If you do not know, leave blank.

HepB (shot) _____
Flu vaccine (shot) _____
Pneumonia vaccine (shot) _____
Tetanus Diphtheria vaccine (shot) _____
Bone Density Scan _____
Colonoscopy _____
Echocardiogram _____
Eye Glaucoma Exam _____
Hearing Exam _____
Hemocult stool cards _____
Lipid Panel _____
Mammogram (female) _____
Pap Smear (female) _____
Pelvic Exam _____
Prostate Rectal Exam (male) _____
PSA Test (male) _____

PAST MEDICAL

Specialists currently see (e.g.: cardiologist, dermatologist)

Name / Specialty

1) _____
2) _____

Name / Specialty

3) _____
4) _____

ALLERGIES

List any allergies to medication, x-ray dyes, or food.

Allergy	**Reaction**

MEDICATIONS

List any medication/supplements that you currently take, including over-the-counter.

Name	Strength	Direction	Prescribed by

Patient Name: _____ **Date of Birth:** _____

PAST MEDICAL HISTORY CONT'D

List any recent hospital stay in the last year. What hospital?

	Reason	Date		Reason	Date
1)			**4)**		
2)			**5)**		
3)			**6)**		

List any recent surgeries in the last 5 years

	Reason	Date		Reason	Date
1)			**4)**		
2)			**5)**		
3)			**6)**		

list DME (medical suppliers) for oxygen, cpap, walkers, etc.

	Name		Name
1)		**4)**	
2)		**5)**	
3)		**6)**	

FAMILY HISTORY

Please list any health problem updates

	Medical Problems
Father	
Mother	
Brother(s)	
Sisters(s)	
Mother's father Mother's mother	
Father's father Father's mother	

SOCIAL HISTORY

Do you drink alcohol?..... ☐ No ☐ Yes *If yes how much / what kind?* _____

Are others concerned about your drinking? ☐ No ☐ Yes

Do you do some form of regular exercise every day? ☐ No ☐Yes

If yes, how much? _____

Have you ever smoked or chewed tobacco? ..... ☐No ☐ Yes *If yes, how much/what kind?* _____

Quit smoking? .... ☐No ☐ Yes *If yes, when?* _____

Patient Name: _____ **Date of Birth:** _____

Functional Ability and Level of Safety

Shopping
1. Can you take care of all shopping needs independently? ☐Yes ☐No
2. If No, who helps with shopping needs?
_____

Food Preparation
1. Can you prepare and serve adequate meals independently? ☐Yes ☐No
2. If No, who helps with meals? _____

Self Care
1. Do you have difficulty feeding yourself?
☐ Yes ☐ No
2. Do you have difficulty (self-care such as) washing all over or dressing? ☐ Yes ☐ No
3. Are you able to use the bathroom independently? ☐ Yes ☐ No
4. If No, who helps with assistance?
_____
5. Do you require hand rails and shower chair in the bathroom? ☐ Yes ☐ No

Housekeeping
1. Can you maintain house alone (e.g. yard work and house cleaning) or with occasional assistance? _____
2. Can you perform light daily task such as dish washing, bed making? ☐ Yes ☐ No
3. Able to do personal laundry alone?
☐ Yes ☐ No
4. If No, who helps with assistance?
_____

Mode of Transportation
1. Can you travel independently by driving your own car? ☐ Yes ☐ No
2. If No, what is your mode of transportation and who accompanies you during travel?
_____

Medications
1. Are you responsible for taking medication in correct dosages at correct time? ☐ Yes ☐ No
2. If No, who prepares medications for you?
_____

Finances
1. Are you able to manage financial matters independently (budgets, writes checks, pay bills, goes to bank) and manage day-to-day purchases? ☐ Yes ☐ No
2. If No, who helps with financial matters?
_____

Safety Risk Assessment

	Yes	No
1. Do you live alone?	☐	☐
2. Do you live in an assisted living facility?	☐	☐
3. Do you have diffuculty seeing?	☐	☐
4. Do you wear glasses or contacts?	☐	☐
5. Do you have difficulty hearing?	☐	☐
6. Do you use hearing aid?	☐	☐
7. Is there any family violence in the home?	☐	☐
6. Do you have any sleep disturbances?	☐	☐

Patient Name: _____ **Date of Birth:** _____

Mobility

	Yes	No
1. Are you afraid of falling?	☐	☐
2. Have you fallen in the past year?	☐	☐
a. What caused your fall/Injury? _____		
3. Do you have difficulty walking?	☐	☐
4. Do you use a cane, walker or wheelchair for assistance?	☐	☐
5. Do you exercise?	☐	☐
a. What do you do? _____		
b. How often do you do it? _____		

Cognitive Function

1. Are you having any problem with memory impairment, such as forgetfulness? ☐ Yes ☐ No
2. Are you having problems with speech, such as slurred or slowed speech? ☐ Yes ☐ No

Depression

In the past 6 months have you felt any of the following:

a) Have you had the feeling of feeling nervous, lonely, or blue? ☐ Yes ☐ No

b) Have you felt the need to want to harm yourself? ☐ Yes ☐ No

ADVANCE DIRECTIVE

Do you have an Advanced Directive (living will, DNR)? ☐ No ☐ Yes (please bring a copy)

Notes: _____

_____

_____

Authorized Signature: _____ Date: _____

Reviewed by: _____ Date: _____