CompleteCare
Family Medicine

Medicare Annual Wellness Visit Forms

To: Our Medicare Patients:
Subject: Medicare Annual Wellness and Other Preventive Visits

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 first twelve months as a Medicare patient. You may receive your Annual Wellness Visit after you have been with Medicare for more than one year, or it has been at least one year since your "Welcome to Medicare" exam.

Initial Preventive Physical Exam (IPPE)	"Welcome to Medicare" is only for *new* Medicare patients. This must be done in the 1st year as a Medicare patient.
Annual Wellness Visit, Initial	At least 1 yr after the "Welcome to Medicare" exam.
Annual Wellness Visit, Subsequent	Once a year (more than 1 yr + 1 day after the last Wellness Visit).

The Annual Wellness Visit is not the same thing as what many people often refer to as their yearly physical exam. 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 your 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 problems, conditions, or medications. You may schedule another visit to address those issues or your doctor may charge the usual Medicare fees for such services that are beyond the scope of the Annual Wellness Visit***.

If you would like to schedule an annual physical, including any lab work or other diagnostic testing, medication management, vaccinations, and other services, please understand that these services will be charged and covered according to Medicare's usual coverage guidelines. However, you may still develop a care plan based on the Annual Wellness Visit criteria.

We appreciate the trust you put in us to take care of your health care needs and hope that you will take advantage of this new benefit to work with your physician in creating your personalized prevention plan.

See the attached list to bring with you to your appointment, or come 15 minutes prior to fill out.

Patient Name: _____ **D.O.B.:** _____

Have you had any tests done in the past year? ___ Yes ___ No (such as blood tests, colonoscopy, mammograms, x-rays, CT scan, MRI, etc.)

Test Name	Date

Have you had any recent immunization? ____ Yes _____No

If yes please list:

Do you have a living will or advance directive? ____ Yes _____No
(if you have one, please bring a copy to office for our records)

HEALTH RISK ASSESSMENT

1. **Can you get places out of walking distance without help?*for example, can you travel alone by bus, taxi, or drive your own car?**
   - Yes
   - No
2. **Can you shop for groceries or clothes without help?**
   - Yes
   - No
3. **Can you prepare your own meals?**
   - Yes
   - No
4. **Can you do your own housework without help?**
   - Yes
   - No
5. **Can you handle your own money without help?**
   - Yes
   - No
6. **Do you need help eating, bathing, dressing, or getting around your home?**
   - Yes
   - No
7. **Are you having difficulties driving your car?**
   - No
   - Sometimes
   - Yes, often
   - Not applicable, I do not use a car
8. **Have you been given any information to help you keep track of your medications?**
   - Yes
   - No

9. **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

10. **During the past 4 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

11. **How often in the past 4 weeks, have you had trouble eating well?**
    - Never
    - Seldom
    - Sometimes
    - Often
    - Always

12. **How often in the past 4 weeks, have you been bothered by your teeth or dentures?**
    - Never
    - Seldom
    - Sometimes
    - Often
    - Always

13. **How often in the past 4 weeks, have you had problems using the telephone?**
    - Never
    - Seldom
    - Sometimes
    - Often

14. **Have you been given any information to help you identify hazards in your house that might hurt you?**
    - Yes
    - No

15. **Do you always fasten your seatbelt when you are in a car?**
    - Yes, Usually
    - Yes, Sometimes
    - No

16. **Have you had sex in the past 12 months (vaginal, oral or anal)?**
    - Yes
    - No

17. **Have you ever had a sexually transmitted disease?**
    - Yes
    - No

18. **During the past 4 weeks, how much bodily pain have you generally had?**
    - No pain
    - Very mild pain
    - Mild pain
    - Moderate pain
    - Severe pain

19. **During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?**
    - Very heavy
    - Heavy
    - Moderate
    - Light
    - Very light

20. **During the past 4 weeks, how would you rate your general health?**
    - Excellent
    - Very good
    - Good
    - Fair
    - Poor
21. **How have things been going for you in the past 4 weeks?**
    - Very well – could hardly be better
    - Pretty good
    - Good and bad are about equal
    - Pretty bad
    - Very bad – could hardly be worse
22. **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
23. **Over the past 2 weeks, have you experienced having little interest or pleasure in doing things?**
    - Yes
    - No
24. **Over the past 2 weeks, have you been feeling down, depressed or hopeless?**
    - Yes
    - No
25. **Are you a smoker?**
    - No
    - Yes, and I might quit
    - Yes, but I am not ready to quit
26. **Did you have a drink containing alcohol in the past year?**
    - Yes
    - No
27. **Have you fallen two (2) or more times in the past year?**
    - Yes
    - No
28. **Were you injured in any falls in the past year?**
    - Yes
    - No
29. **How often in the last 4 weeks have you experienced the following: Hearing loss screening:**
    - Straining to understanding conversation
        - Never
        - Seldom Sometimes
        - Often
        - Alwways
    - Trouble hearing in noisy background
        - Never
        - Seldom
        - Sometimes
        - Often
        - Always
    - Misunderstand what others are saying
        - Never
        - Seldom
        - Sometimes
        - Often

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, 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 difficult _____

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CAGE Questionnaire for Detecting Alcoholism

Question	Yes	No
C: Have you ever felt you should **C**ut down on your drinking?	1	0
A: Have people **A**nnoyed you by criticizing your drinking?	1	0
G: Have you ever felt **G**uilty about your drinking?	1	0
E: Have you ever had a drink first thing in the morning (**E**ye opener)?	1	0

A total score of 0 or 1 suggests low risk of problem drinking
A total score of 2 or 3 indicates high suspicion for alcoholism
A total score of 4 is virtually diagnostic for alcoholism

COGNITIVE WELLNESS QUESTIONNAIRE

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS:

- ☐ Memory Loss (such as forgetting appointments, family occasions, holidays)
- ☐ Confusion to time or place
- ☐ Issues with sleep
- ☐ Difficulty finding words or writing
- ☐ A failing sense of direction (lost in familiar places)
- ☐ Change in mood or personality (confused, depressed, fearful, anxious)
- ☐ Difficulty completing familiar tasks at home, work or at leisure
- ☐ Misplacing things or losing the ability to retrace steps
- ☐ Decrease in appetite

PLEASE INCLUDE ANY COGNITIVE OR MOOD CONCERNS:

(that are not listed above)

_____

_____

_____

_____

_____

PATIENT NAME: _____ ***D.O.B.:*** _____

Circle current symptoms

CONSTITUTIONAL
Chills
Decline in Health
Fatigue
Fever
Weakness
Weight gain
Weight loss

HEAD
Dizziness
Fainting
Head Injury
Headaches
Pain
Sweats

EYES
Blurry vision
Cataracts
Discharge
Double Vision
Excessive tearing
Eye pain
Eyeglass use
Glaucoma
Infections
Pain with Light
Recent Injury
Redness
Unusual sensations
Vision Loss

ENT

Nose
Discharge
Frequent Colds
Hay Fever
Infections
Nasal Obstruction
Nosebleeds
Sinus Infections

Mouth
Bleeding gums
Change in Dentition
Hoarseness
Postnasal drip
Tongue Burning
Voice changes

Ears
Discharge
Dizziness
Hearing aid
Hearing impairment
Infections
Pain
Ringing in ears

Neck
Frequent sore throats
Lumps
Tonsils enlarged
Tenderness

RESPIRATORY
Asthma
Bronchitis
Cough
Coughing Blood
Pain
Pleurisy
Positive TB test
Recent Chest X-ray
Shortness of Breath
Sputum
Tuberculosis
Wheezing

CARDIOVASCULAR
Chest Pain
Extremity(s) Cool
Extremity(s)Discolor
Hair loss on legs
Heart murmur
Heart Tests (Not EKG)
High Blood Pressure
Hx of Heart Attack
Leg Pain - Walking
Palpitations
Recent EKG
Rheumatic Fever
SOB - Exertion
SOB - Lying Flat
Short of Breath - Sleeping
Swelling of Legs
Thrombophlebitis
Ulcers on legs
Varicose veins

GASTROINTESTINAL
Abdominal Pain
Abdominal Xray Test
Antacid use
Black Tarry Stools
Change in frequency
Change in stool color
Change in stool caliber
Change in stool consistency
Constipation
Decreased appetite
Diarrhea
Excessive hunger
Excessive thirst
Gallbladder disease
Heartburn
Hemorrhoids
Hepatitis
Infections
Jaundice
Laxative use
Liver disease
Nausea
Rectal pain/bleed
Swallowing diff
Vomiting
Vomiting Blood

MUSCULOSKELETAL
Arthritis
Back/neck Problems
Deformities
Gout
Joint Pain/Stiffness
Muscle Cramps/stiffness
Paralysis
Restricted Motion
Weakness

PSYCHIATRIC
Behavioral Change
Depression
Disorientation
Disturbing thoughts
Excessive Stress
Hallucinations
Memory Loss
Mood changes
Nervousness
Psychiatric disorders

BREAST
Discharge
Lumps
Pain
Self-Examination
Tenderness

OVER ->

SKIN
Dryness
Easy bruisability
Eczema
Hair dye
Hair texture change
Hives
Itching
Lumps
Mole Increased Size
Nail appearance change
Nail texture change
Rashes
Skin Color Change

NEUROLOGICAL
Blackouts
Burning
Dizziness
Fainting
Head Injury
Headaches
Loss of consciousness
Memory loss
Numbness
Speech disorders
Strokes
Tingling
Tremors
Unsteady gait

ENDOCRINE
Cold Intolerance
Excessive Urination
Fatigue
Goiter
Heat Intolerance
Increased thirst
Neck Pain
Sweats
Thyroid trouble
Weakness
Weight gain/loss

HEMATOLOGIC/ LYMPH
Anemia
Bleeding Easily
Blood Clots
Easy bruising
Lumps
Radiation Exposure
Swollen Glands
Transfusion Reaction

ALLERGIC/IMMUNE
Coughing
Coughing with Exercise
Hives
Itchy eyes / nose
Recurrent Infections
Runny nose
Sneezing
Stuffy nose
Watery eyes
Wheezing
Wheezing with exercise

URINARY
Awakening to Urinate
Bed-Wetting
Burning on urination
Pain on urination
Difficulty start/stop stream
Excessive urination
Flank pain
Frequency
Incontinence
Infections
Retention
Stones
Urgency
Urine discoloration
Urine odor

FEMALE
Birth control
Bleeding Between Periods
Change in pd Duration
Change in pd flow
Change in pd interval
DES Exposure
Difficult Pregnancy
Discharge
Fertility problems
Hernia
Itching
Lesions
Menopause
Menstrual pain
Pain on Intercourse
Postmenopausal Bleeding
Recent PAP Smear
Recent Pregnancy
Sexual Problems
Venereal Disease

MALE
Fertility Problems
Hernias
Impotence
Lesions
Pain
Prostate problems
Scrotal Masses
Sexual Problems
Venereal disease

Patient Signature: _____ ***Date:*** _____