A WORD TO OUR PATIENTS ABOUT MEDICARE AND WELLNESS CARE

Dear Patient,

Your appointment for your Medicare Annual Wellness Visit is scheduled for ____. 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 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. But 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 develop a plan to keep you healthy. At your wellness visit, our health care team will:

- Review your complete medical history
- Complete screenings to detect depression, risk for falling and other problems
- Complete a limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity
- Review your risk factors
- Develop a personalized prevention plan to keep you healthy
- Recommend other wellness services and healthy lifestyle changes.

In order to prepare for your upcoming annual wellness visit, **please complete the information included in this packet and bring it with you to your visit**. Please ensure that you provide a COMPLETE list of ALL medications and supplements. Please ensure that you provide a COMPLETE list of all other medical providers participating in your care. ***Please return these forms to our receptionist at check in on the day of your Annual Wellness Visit.***

Medicare is very specific about what services must be provided and documented during your wellness visit. A wellness visit does not address new or existing health problems. Please let our scheduling staff know if you need the medical provider's help with a health problem, a medication refill or something else. We will need to schedule a separate appointment for these services. *A separate charge applies to these services.*

Thank you for actively participating in your healthcare and taking the time to provide this detailed information that will allow us to provide this comprehensive service as efficiently as possible

Warmest regards,

Adam A. Brunson, MD

Bonnie Davis, APRN

Name: ______________________________________ Date of Birth: _______________ Today's Date: ________________

Medicare Annual Wellness Visit Health Risk Assessment

Please complete this checklist prior to seeing your medical provider. Your answers will help you receive the best health care possible.

General Health

1. In general, how would you rate your overall health?
   - ❑ Excellent
   - ❑ Very good
   - ❑ Good
   - ❑ Fair
   - ❑ Poor

2. How many hours of sleep do you usually get each night?
   - ❑ More than 8 hours
   - ❑ 6-8 hours
   - ❑ 4-5 hours
   - ❑ Less than 4 hours

3. During the **past year**, how much bodily pain have you generally had?
   - ❑ No pain
   - ❑ Very mild pain
   - ❑ Mild pain
   - ❑ Moderate pain
   - ❑ Severe pain

4. How many times in the last 6 months have you been to the emergency room?
   - ❑ 0
   - ❑ 1-2
   - ❑ 3-4
   - ❑ 5+
   - ❑ I don't know

5. How many times in the last 6 months were you admitted to the hospital?
   - ❑ 0
   - ❑ 1-2
   - ❑ 3-4
   - ❑ 5+
   - ❑ I don't know

Physical Activity

6. Do you usually get at least 150 minutes of moderate aerobic activity (like brisk walking) or 75 minutes of vigorous aerobic activity (like jogging) per week?
   - ❑ Yes
   - ❑ No
   - ❑ I do not exercise

7. Do you do strength training exercises for all major muscle groups at least two times per week?
   - ❑ Yes
   - ❑ No
   - ❑ I do not exercise

Nutrition

8. Do you usually eat a diet that has at least 4 servings of fruit and vegetables, includes fiber/whole grains and avoids (other than occasional servings) high fat foods and sweets?

   ❑ yes ❑ no

9. On a typical day, how many sugar-sweetened drinks do you drink?

   _________ drinks per day

10. On a typical day, how many 8 oz. glasses of water do you drink?

    _________ glasses per day

Oral Health

11. How would you describe the condition of your mouth and teeth (including false teeth or dentures)?
    - ❑ Excellent
    - ❑ Very good
    - ❑ Good
    - ❑ Fair
    - ❑ Poor

12. Do you visit the dentist regularly?

    ❑ yes ❑ no

Functional Status

13. Do you need the help of another person with your personal care needs such as eating, bathing, dressing, using the toilet or getting around the house?

    ❑ yes ❑ no

14. Do you need help using the telephone?
 ❑ yes ❑ no

15. Do you need help with shopping for groceries or clothes?
 ❑ yes ❑ no

16. Do you need help with preparing meals?
 ❑ yes ❑ no

17. Do you need help with housekeeping?
 ❑ yes ❑ no

18. Do you need help with laundry?
 ❑ yes ❑ no

19. Do you need help getting to places out of walking distance? (For example, traveling alone on buses or taxis, or driving your own car?)
 ❑ yes ❑ no

20. Do you need help taking your medications?
 ❑ yes ❑ no

21. Do you need help managing your money?
 ❑ yes ❑ no

22. Are you having difficulties driving your car?
 ❑ Yes, often
 ❑ Sometimes
 ❑ No
 ❑ Not applicable; I do not drive a car

23. Do you have any hearing problems?
 ❑ yes ❑ no

24. Do you have any vision problems?
 ❑ yes ❑ no

25. Do you or your family have any concerns about your memory?
 ❑ yes ❑ no

Safety Screening

26. Have you fallen 2 or more times, or had a fall with injury, in the **past year**?
 ❑ yes ❑ no

27. Do you feel unsteady when you walk or have trouble with your balance?
 ❑ yes ❑ no

28. Do you have loose rugs/slippery floors in your home?
 ❑ yes ❑ no

29. Are grab bars present in the bathroom?
 ❑ yes ❑ no

30. Are hand rails present on the stairs?
 ❑ yes ❑ no ❑ N/A

31. Is there obtrusive furniture or clutter in your home?
 ❑ yes ❑ no

32. Is there poor lighting in your home?
 ❑ yes ❑ no

33. Do you always wear your seatbelt when you are in the car?
 ❑ yes ❑ no

34. Do you ever drive after drinking alcohol, or ride with a driver who has been drinking?
 ❑ yes ❑ no

35. Do you have functional smoke detectors in your home?
 ❑ yes ❑ no

36. Do you protect yourself from the sun when you are outdoors?
 ❑ yes ❑ no

Social History

37. Are you a smoker?
 ❑ Never smoked
 ❑ Former smoker
  Quit date: _____________
 ❑ Yes, and I might quit
 ❑ Yes, but I am not ready to quit

38. Do you use a smokeless tobacco product?
 ❑ yes ❑ no

39. Think about your drinking in the past year. A drink means 12 oz. of beer, 5 oz. of wine or 1.5 oz. of 80 proof liquor.
    a. How often do you have a drink containing alcohol?
    - ❑ Daily
    - ❑ 4-6 times per week
    - ❑ 2-3 times per week
    - ❑ Weekly
    - ❑ Monthly
    - ❑ Less than monthly
    - ❑ Never

    b. How many drinks containing alcohol do you consume on a typical day you are drinking?
    - ❑ 10 or more
    - ❑ 7-9
    - ❑ 5-6
    - ❑ 4
    - ❑ 3
    - ❑ 2
    - ❑ 1

    c. How often do you have (5 for men; 4 for women & men over age 65) or more drinks on one occasion?
    - ❑ Daily
    - ❑ 4-6 times per week
    - ❑ 2-3 times per week
    - ❑ Weekly
    - ❑ Monthly
    - ❑ Less than monthly
    - ❑ Never

40. In the past year, have you used an illegal drug or used a prescription medication for nonmedical reasons?
    ❑ yes ❑ no

Mental Health

41. Over the **past two weeks**, how often have you had little interest or pleasure in doing things?
    - ❑ Not at all
    - ❑ Several days
    - ❑ More than half the days
    - ❑ Nearly every day

42. Over the **past two weeks**, how often have you felt down, depressed or hopeless?
    - ❑ Not at all
    - ❑ Several days
    - ❑ More than half the days
    - ❑ Nearly every day

43. Over the **past two weeks,** how often have you felt nervous, anxious or on edge?
    - ❑ Not at all
    - ❑ Several days
    - ❑ More than half the days
    - ❑ Nearly every day

44. Over the **past two weeks**, has your emotional health limited your social activities with family, friends, neighbors, or groups?
    - ❑ Not at all
    - ❑ Slightly
    - ❑ Moderately
    - ❑ Quite a bit
    - ❑ Extremely

45. How often do you get the social and emotional support you need?
    - ❑ Always
    - ❑ Usually
    - ❑ Sometimes
    - ❑ Rarely
    - ❑ Never

End of life planning

46. Do you have any of the following advance directives?
    - ❑ Living will/advance directive
    - ❑ Do not resuscitate order
    - ❑ Durable power of attorney
    - ❑ Health care proxy
    - ❑ No formal document

47. Have you discussed your end of life wishes with your family?
    ❑ yes ❑ no

48. Would you like more information on advance directives?
    ❑ yes ❑ no

Name: ______________________________________ Date of Birth: _______________ Today's Date: ________________

Constitutional
- ☐ Chills
- ☐ Excessive fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weight gain (unintentional)
- ☐ Weight gain (intentional)

Eyes
- ☐ Loss of vision
- ☐ Blurry vision
- ☐ Eye drainage
- ☐ Eye pain
- ☐ Red eye
- ☐ Itchy eyes
- ☐ Spots before your eyes
- ☐ Glasses/contact lenses

Ears, Nose & Throat
- ☐ Loss of hearing
- ☐ Ringing in the ears
- ☐ Ear pain
- ☐ Frequent runny nose
- ☐ Frequent nose bleeds
- ☐ Nasal congestion
- ☐ Bleeding gums
- ☐ Loss of smell
- ☐ Loss of voice
- ☐ Sore throat
- ☐ Sore tongue
- ☐ Tooth pain
- ☐ Dentures
- ☐ Hearing aids

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Swollen ankles/feet
- ☐ Fainting spells
- ☐ Irregular heart beat
- ☐ Fast heart beat
- ☐ Leg/calf pain with walking
- ☐ Dizziness
- ☐ Shortness of breath when lying flat
- ☐ Varicose veins

Respiratory
- ☐ Recent cough
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Exposure to TB

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Stomach/abdomen pain
- ☐ Loss of appetite
- ☐ Bloating
- ☐ Constipation

Gastrointestinal (continued)
- ☐ Diarrhea
- ☐ Frequent heartburn/acid reflux
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Bloody stools
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Change in appearance of stool

Genitourinary
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Leakage of urine
- ☐ Waking up to urinate at night
- ☐ Frequent need to urinate
- ☐ Change in urine stream
- ☐ Genital sores/rashes
- ☐ Pelvic pain
- ☐ Frequent urinary infections

Male Only
- ☐ Difficulty with erections
- ☐ Lump on testicle
- ☐ Painful erections
- ☐ Penile discharge

Female Only
- ☐ Painful intercourse
- ☐ Bleeding after intercourse
- ☐ PMS (premenstrual tension)
- ☐ Heavy periods
- ☐ Frequent periods
- ☐ Infrequent periods
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Vaginal itching
- ☐ Menopausal
- ☐ Currently using birth control
- ☐ Currently/possibly pregnant
- ☐ Currently breastfeeding

Musculoskeletal
- ☐ Painful joints
- ☐ Stiff joints
- ☐ Joint swelling
- ☐ Red, hot, tender joints
- ☐ Back pain
- ☐ Neck pain
- ☐ Muscle pain

Skin/Breast
- ☐ Acne
- ☐ Changing/new moles
- ☐ Dry skin
- ☐ Nail changes
- ☐ Jaundice

Skin/Breast (continued)
- ☐ Itching
- ☐ Rash
- ☐ Warts
- ☐ Breast lump
- ☐ Breast skin changes
- ☐ Breast tenderness
- ☐ Nipple discharge

Neurologic
- ☐ Loss of balance
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Memory loss
- ☐ Numbness/tingling
- ☐ Seizures/convulsions
- ☐ Tremors
- ☐ Vertigo
- ☐ Weakness

Hematologic/Lymphatic
- ☐ Excessive bleeding
- ☐ Increased bleeding
- ☐ History of blood transfusion
- ☐ Enlarged lymph nodes/glands

Endocrine
- ☐ Enlarging hands/feet
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive hair growth
- ☐ Hot flashes
- ☐ Increased skin pigmentation
- ☐ Infertility
- ☐ Excessive thirst
- ☐ Excessive sweating
- ☐ Excessive hunger

Allergic/Immunologic
- ☐ Allergies/hayfever
- ☐ Hives
- ☐ Frequent colds/sinus infections
- ☐ Immune system disorder

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Crying spells
- ☐ Mood swings
- ☐ Feeling stressed
- ☐ Loss of interest in pleasurable activities
- ☐ Sadness
- ☐ Poor concentration
- ☐ Difficulty sleeping
- ☐ Sleeping too much
- ☐ Thoughts of suicide

Name: ___________________________________ Date of Birth: ______________ Today's Date: _______________

Medication list

Name of Medication	Dosage	Directions

Hospitalizations within last three years

Reason for Hospital Visit	Facility	Attending Physician	Date

Do you have any specific medical concerns that you would like to address? Please note that these concerns will likely require a separate office visit to appropriately evaluate and treat.

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____

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Name: ____ Date of Birth: ________________ Today's Date: _________________

Other providers participating in your healthcare

Please help us ensure that our office has all treating providers current in your chart. Please provide first and last name of doctors or nurse practitioners below. Simply write NA if you do not treat with someone in the specialty listed below.

Primary Care Physician: _____________________________ Date of last visit: ___________

Allergist: _____________________________ Date of last visit: ___________

Cardiologist: _____________________________ Date of last visit: ___________

Chiropractor: _____________________________ Date of last visit: ___________

Dentist: _____________________________ Date of last visit: ___________

Dermatologist: _____________________________ Date of last visit: ___________

Endocrinologist: _____________________________ Date of last visit: ___________

ENT: _____________________________ Date of last visit: ___________

Gastroenterologist: _____________________________ Date of last visit: ___________

Gynecologist: _____________________________ Date of last visit: ___________

Nephrologist: _____________________________ Date of last visit: ___________

Neurologist: _____________________________ Date of last visit: ___________

Oncologist: _____________________________ Date of last visit: ___________

Ophthalmologist (Eye): _____________________________ Date of last visit: ___________

Orthopedic Surgeon: _____________________________ Date of last visit: ___________

Pain Management: _____________________________ Date of last visit: ___________

Psychiatrist: _____________________________ Date of last visit: ___________

Psychologist: _____________________________ Date of last visit: ___________

Pulmonologist: _____________________________ Date of last visit: ___________

Rheumatologist: _____________________________ Date of last visit: ___________

Sleep Doctor: _____________________________ Date of last visit: ___________

Urologist: _____________________________ Date of last visit: ___________

____________________: _____________________________ Date of last visit: ___________

____________________: _____________________________ Date of last visit: ___________