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**. Also, **review the attached immunization list**. If you have received any immunizations that are not listed, **please list them**. ***Please return these forms to our receptionist at check in on the day of your Annual Wellness Visit.***

Medicare is very specific about what the Annual Wellness Visit includes and excludes. A wellness visit does not address new or existing health problems. That would be a separate service and requires a longer appointment. 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 may need to schedule a separate appointment. *A separate charge applies to these services, whether provided on the same date or a different date than the wellness visit.*

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

Warmest regards,

Adam A. Brunson, MD

Name: _____ Date: _____ Date of Birth: _____

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. Compared to one year ago, how would you rate your current overall health?
   - ❑ Much better
   - ❑ Somewhat better
   - ❑ About the same
   - ❑ Somewhat worse
   - ❑ Much worse

3. 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

4. How often do you feel unusually tired?
   - ❑ Never, rarely
   - ❑ Sometimes
   - ❑ Often
   - ❑ Always

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

Physical Activity

6. How many days a week do you usually exercise?
   _____ days per week

7. On days when you exercise, for how long do you usually exercise?
   _____ minutes per day

8. How intense is your typical exercise?
   - ❑ Light (like slow walking)
   - ❑ Moderate (like brisk walking)
   - ❑ Heavy (like jogging)
   - ❑ Very heavy (like sprinting)
   - ❑ I do not exercise

Nutrition

9. On a typical day, how many servings of fruits and/or vegetables do you eat? (1 serving = 1 cup fresh vegetables, ½ cup cooked vegetables or 1 medium piece of fruit)
   _____ servings per day

10. On a typical day, how many servings of high fiber or whole grain foods do you eat? (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high fiber ready to eat cereal or ½ cup cooked cereal, brown rice or whole wheat pasta)
    _____ servings per day

11. On a typical day, how many servings of fired or high-fat foods do you eat? (examples include fried chicken, fried fish, bacon, French fries, potato chips, creamy salad dressings or mayonnaise)
    _____ servings per day

12. On a typical day, how many caffeinated drinks (coffee, tea, soda) do you drink?
_____ drinks per day

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

Oral Health

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

15. How often do you brush your teeth and/or dentures?
- ❑ At least once daily
- ❑ Most days of the week
- ❑ Seldom
- ❑ Never

16. How often do you floss your teeth?
- ❑ At least once daily
- ❑ Most days of the week
- ❑ Seldom
- ❑ Never
- ❑ Not applicable

17. Do you visit the dentist regularly?
❑ yes ❑ no

Functional Status

18. 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

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

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

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

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

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

24. 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

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

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

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

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

29. Do others complain about your hearing?
❑ yes ❑ no

Safety Screening

30. Have you fallen in the **past year**?
❑ yes ❑ no

31. Do you feel unsteady when you walk or get dizzy when you stand up?
❑ yes ❑ no

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

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

34. Are handrails present on the stairs?
❑ yes ❑ no ❑ N/A

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

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

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

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

39. Is the hot water temperature set below 120 degrees?
    ❑ yes ❑ no

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

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

Social History

42. Please describe your home environment.
    ❑ Private home
    ❑ Assisted living
    ❑ Other: _____

43. How many people live in your home?
    _____ persons

44. What is your marital status?
    ❑ Married
    ❑ Single
    ❑ Divorced
    ❑ Separated
    ❑ Widowed

45. Are you sexually active?
    ❑ Yes, with a monogamous partner
    ❑ Yes, with multiple partners
    ❑ No, not currently sexually active

46. My sexual partners are?
    ❑ Male
    ❑ Female
    ❑ Male and female
    ❑ Not applicable

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

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

49. During an average week, how many drinks of wine, beer, or other alcoholic beverages do you usually 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

50. Do you use street drugs?
    ❑ Prior use
    ❑ Daily
    ❑ Occasionally
    ❑ Never

Mental Health

51. 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

52. 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

53. 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

54. How often is stress/anger a problem for you?
    - ❑ Never or rarely
    - ❑ Sometimes
    - ❑ Often
    - ❑ Always

55. How well do you handle the stress/anger in your life?
    - ❑ I'm usually able to cope effectively
    - ❑ At times I have problems coping
    - ❑ I often have problems coping

56. 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

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

End of life planning

58. Do you have a do not resuscitate order?
    ❑ yes ❑ no

59. Do you have a durable power of attorney?
    ❑ yes ❑ no

60. Do you have a living will or advance directive?
    ❑ yes ❑ no

61. Have you discussed your wishes with your family?
    ❑ yes ❑ no

Patient Name:_____ DOB:_____

Review of Body Systems: Check all symptoms/problems that you are currently experiencing

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

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
- ☐ Diarrhea

Gastrointestinal (continued)
- ☐ 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
- ☐ Itching
- ☐ Rash

Skin/Breast (continued)
- ☐ 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 bruising
- ☐ 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

Patient Name:_____ DOB:_____

Medication list

Name of Medication	Dosage	Directions

Other providers participating in your healthcare

Name of Provider	Specialty of Provider	Type of Care	Date of Last Visit
	Eye doctor, if applicable		
	Dentist, if applicable		
	Gynecologist, if applicable		

Hospitalizations within last three years

Reason for Hospital Visit	Facility	Attending Physician	Date

Do you have any health improvement opportunities or medical concerns you would like to address?

_____

_____

_____