Manatee Physician Alliance

Name: _____

Date of Birth: _____

Today's Date: _____

Medicare Wellness Visit

Your Medicare benefits include a yearly prevention visit. At age 65 until you are age 66, you are allowed one "Welcome to Medicare" prevention visit. Now, since 2011, you can also have one Annual Wellness Visit Yearly. The Annual Wellness Visit is fully paid by Medicare without a deductible or co-pay.

During this visit your physician will:

- Concentrate on preventive medicine.
- Focus on identifying factors that may represent a risk for further medical problems and will work with you to reduce these risks.
- Review your medical problems, medications, and other doctors that you see; inquire about depression and disabilities; and recommend programs for further evaluation including tests tailored to the findings of your visit.

******* The Wellness Visit prevention exam is provided without any cost to you, but does not include the cost of medical treatment.* ***If needed, a follow-up appointment will be scheduled to address any additional issues or concerns. *****

_____ _____

Patient Signature Date

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Annual Physical Questionnaire

List below names of all current doctors:

Name of Doctor	Specialty	Name of Doctor	Specialty

Have you been to the Emergency Room or Hospital in the last year? If so, please provide details:

Date	Hospital/ER	Reason for Admission

Has any of your immediate family had any health changes? ☐ Yes ☐ No

If yes, explain: _____

Has your mood changed? ☐ Yes ☐ No

Do you ever feel worried, anxious, or sad? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

Please check all that apply: ☐ One Partner ☐ Multiple Partners ☐ With Women ☐ With Men ☐ Both

If you were born between 1945 and 1965, have you been tested for Hepatitis C? ☐ Yes ☐ No

When was your last:

For	Screening	Date	For	Screening	Date
All	For all:		Women	Mammogram	
	Colonoscopy			Pap smear	
	Glaucoma screening			Bone Density (DEXA)	
Men	PSA—Prostate levels		Men	PSA	
Smokers	Lung Cancer Screening		Men who have smoked	Abdominal Aortic Aneurysm Screening	

Immunizations:

	Date		Date
Tetanus (Td or TDAP)		Pneumonia (Prevnar13/Pneumovax23)	
Flu (Influenza)		Shingles (Shingrix)	

Do you have a Living Will or Advance Directive? *If yes, please bring a copy with you* ☐ Yes ☐ No

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Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(*Check your answer*)

	Not at all	Several days	More than half of 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 fidgety 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 thoughts of hurting yourself or others	0 ☐	1 ☐	2 ☐	3 ☐

Add Columns _____ + _____ + _____ + _____

TOTAL _____

(*Check your answer once again)*

	Not at all difficult	Somewhat difficult	Very difficult	Extremely difficult
10. If you circled any of the problems above, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people.	☐	☐	☐	☐

(Healthcare professional: For interpretation ot TOTAL, please refer to score card)

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Medicare Wellness Visit: Wellness Prescription

Please indicate in the space below your health goals for the next year. You may find the list of items below helpful in setting your goals:

_____

_____

_____

_____

☐ **Tobacco Use:** You have indicated that you are ready to quit smoking/using tobacco
-Set a quit date: _____
- Change when, where, and how much you are smoking
- You may have decided to use a medicinal aid to help; see handout.
- Return to office for further discussion in ___ weeks.

☐ **Activity Level:** You have indicated that you would like to increase your activity level.
-Your current activity level is ____ minutes ___ times a week.
-Increase your current activity level with a goal of at least 30 minutes daily.
Experts recommend at least 30 minutes of physical activity on most days of the week, but you don't have to do all 30 minutes at once. Try walking in 15 minutes twice each day or for 10 minutes 3 times each day. For most people, walking is one of the easiest activities to do. If walking isn't your idea of a good time, try gardening or dancing; go fishing or swimming. The activity should be both enjoyable and good for you.

☐ **Weight Management:** You have indicated that you would like to lose weight. To reach this goal in a healthy way:
-Eat a well-balanced meal; see handouts
-Increase exercise: see above for details.
-Return to the office in ____weeks for further discussion.

☐ **Fall Prevention:** It has been determined during your visit today that you are at increased risk of falls:
-Remove all throw rugs from your home.
-Add grab bars to your bath/shower/toilet area.

☐ **High Blood Pressure:**
-Low Salt (DASH Diet); see handout.
-Decrease weight by changing to healthier lifestyle habits; see handout.

☐ **High Cholesterol:**
-Low Fat Diet; see handout.
-Decrease weight by changing to healthier lifestyle habits; see above.

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Medicare Wellness Visit: Wellness Prescription

Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible.

1. How have things been going for you during the last 4 weeks?
   - ☐ Very well – could hardly be better
   - ☐ Pretty good
   - ☐ Good and bad are about equal
   - ☐ Pretty bad
   - ☐ Very bad – could hardly be worse
2. In general, how is your health?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
3. How is the condition of your mouth and teeth—including false teeth or dentures?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
4. How is your eye sight?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
5. How is your hearing?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
6. In the past 7 days, how much pain have your felt?
   - ☐ None
   - ☐ Some
   - ☐ A lot
7. Are you a smoker?
   - ☐ Yes
   - ☐ No, if ever, when did you quit? _____
8. How many drinks of wine, beer or other alcoholic beverages did you have on average?
   - ☐ 10 or more
   - ☐ 6-9 drinks per week
   - ☐ 2-5 drinks per week
   - ☐ 1 or less drinks per week
   - ☐ I do not drink at all
9. Do you ever drive after drinking or ride with a driver who has been drinking?
   - ☐ Yes
   - ☐ No
10. Do you exercise for about 20 minutes 3 or more days a week?
    - ☐ Yes, most of the time
    - ☐ Yes, some of the time
    - ☐ I am not currently exercising
11. In 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
12. Do you eat three meals a day?
    - ☐ Yes
    - ☐ No: _____
13. How many servings of fruits and vegetables do you eat on a typical day?
    Servings per day: _____
14. How many servings of high fiber or whole grains do you eat on a typical day?
    Servings per day: _____

	Yes	No
15. Can you get places out of walking distance without help?	☐	☐
16. Can you shop for groceries or clothes without help?	☐	☐
17. Can you prepare your own meals?	☐	☐
18. Can you handle your money without help?	☐	☐
19. Do you need help with your medications?	☐	☐
20. Do you need help eating, bathing, dressing or getting around your home?	☐	☐

21. How often is stress a problem for you in handling:
    - Your health
    - Your finances
    - Your family or friendships
    - Your work

    ☐ Almost all of the time
    ☐ Most of the time
    ☐ Some of the time
    ☐ Almost never
22. In the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, angry, downhearted or blue?
    ☐ Almost all of the time
    ☐ Most of the time
    ☐ Some of the time
    ☐ Almost never
23. In the past four weeks, has your physical or emotional health limited your activities with your family or friends?
    ☐ Yes
    ☐ No
24. Do you have someone available to help you if you needed or wanted help; if you felt nervous or lonely, got sick and had to stay in bed, needed someone to help with chores?
    ☐ Yes
    ☐ No: _____
25. Are you having any problems with your memory?
    ☐ Yes
    ☐ No
26. In the last four weeks, how often have you felt sleepy during the daytime?
    ☐ Almost all of the time
    ☐ Most of the time
    ☐ Some of the time
    ☐ Almost never
27. How many hours do you sleep on a typical night?
    _____ hours each night
28. Do you awaken at night?
    ☐ No
    ☐ Yes, how often? _____
29. Are there any hazards in your home that might hurt you; loose rugs, poor lighting?
    ☐ Yes
    ☐ No
30. Have you fallen two or more times in the past year?
    ☐ Yes
    ☐ No
31. Are you afraid of falling or have balance problems?
    ☐ Yes
    ☐ No
32. How often do you have trouble taking your medications the way you have been told to take them?
    ☐ I do not take medication
    ☐ I always take them as prescribed
    ☐ Sometimes I take them as prescribed
    ☐ I seldom take them as prescribed
33. Are you having any difficulty driving your car?
    ☐ Yes, often
    ☐ Sometimes
    ☐ None
    ☐ I do not drive a car
34. Do you wear your seatbelt when you are in the car?
    ☐ Always
    ☐ Usually
    ☐ Never
35. Do you wear sun screen, sun glasses, protective clothing when out in the sun?
    ☐ Yes
    ☐ No
36. How confident are you that you can control and manage most of your health problems?
    ☐ Very confident
    ☐ Somewhat confident
    ☐ Not confident
    ☐ I have no health problems