MEDICARE ANNUAL WELLNESS VISIT

Patient Name: _____ DOB: _____ Visit Date: _____

Medicare encourages a yearly visit with your health care professional to review the preventive services that can help keep you healthy. *This Annual Wellness Visit is not the same thing as a yearly physical exam* although your provider may do a Physical at the same time. The Annual Wellness Visit focuses on gathering your health information and counseling you on improving your health and preventing complications from any illnesses you may currently have or be at risk for.

Please fill out the following pages to the best of your ability. Your health care provider will then discuss your results and create a Personalized Prevention Plan for the next year.

SOCIAL HISTORY AND RISKS

Considering your age, how would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Highest level of Education: _____

Occupation: _____ ☐ Retired

Have you or family members noticed problems with your memory? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No How often? ☐ Daily ☐ 4-6x/week ☐ 1 – 3x/week ☐ less than once/week

What form of exercise? (e.g., jogging, cycling, swimming, yoga): _____

_____ _____

Do you follow a special diet? ☐ Yes ☐ No If yes, specify: _____

Have you recently lost weight without trying? ☐ Yes ☐ No

Have you been unable to eat the amount of food you normally eat because of decreased appetite, fatigue, or shortness of breath? ☐ Yes ☐ No

Do you smoke? (cigarettes, cigars) ☐ Yes ☐ No ☐ Smokeless tobacco

If yes, how many packs per day? _____

Are you interested in quitting? _____

If you have quit, how long ago? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, do you regularly have more than 2 drinks/day? ☐ Yes ☐ No

Do you, family, or friends worry about your alcohol intake? ☐ Yes ☐ No

Do you currently use recreational drugs, including prescription medications not prescribed to you? ☐ Yes ☐ No

Have you ever had problems with drug use, including prescription medications? ☐ Yes ☐ No

If yes, have you received or are you currently receiving treatment? ☐ Yes ☐ No

ACTIVITIES OF DAILY LIVING

Can you get to places out of walking distance from your house? (For example, can you travel alone on buses or taxis, or drive your own car?)	☐ Yes	☐ No	☐ Yes with help
Can you go grocery shopping, clothes shopping, to the bank, or run other errands?	☐ Yes	☐ No	☐ Yes with help
Can you prepare your own meals?	☐ Yes	☐ No	☐ Yes with help
Can you do laundry, clean the house, and other housework?	☐ Yes	☐ No	☐ Yes with help
Can you mange your daily medications?	☐ Yes	☐ No	☐ Yes with help
Can you handle your own money or household finances?	☐ Yes	☐ No	☐ Yes with help
Can you take care of your personal care needs such as eating, bathing, dressing, using the toilet, and getting around the house?	☐ Yes	☐ No	☐ Yes with help

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CURRENT PROVIDERS

Please list all Doctors, Dentists, or Specialists who are currently treating you.

Provider's Name	Specialty and/or Clinic Name

PAST/CURRENT MEDICAL HISTORY

Check any current or previous health issues

☐ Abnormal Pap Smear	☐ CVAD (Cerebral-Vascular Arterial Disease)	☐ Low Testosterone
☐ Alcohol/Drug abuse	☐ Dementia or Alzheimer's	☐ Malaria
☐ Allergic Rhinitis	☐ Depression	☐ Migraines
☐ Anemia, Blood problems	☐ Diabetes	☐ Muscle problems
☐ Anxiety	☐ Diabetic Neuropathy	☐ Obesity
☐ Arthritis	☐ Diverticulitis	☐ Pacemaker
☐ Artificial limb	☐ Dizziness or fainting spells	☐ Paralysis/ numbness/tingling
☐ Asthma	☐ Drug Abuse	☐ Peripheral Neuropathy
☐ Atrial Fibrillation	☐ Epilepsy, seizures (convulsions)	☐ Pneumonia
☐ ADD or ADHD	☐ Erectile Dysfunction (ED)	☐ Prostate Enlargement
☐ Bipolar Disorder	☐ Glaucoma	☐ Recurrent UTIs
☐ Blood clots	☐ GERD/Acid Reflux	☐ Rheumatoid Arthritis
☐ Cancer	☐ Hearing aid/ problems	☐ Schizophrenia
☐ Carotid Artery Disease	☐ Heart valve problems	☐ Shortness of breath
☐ Chest Pain	☐ Hemophilia or excessive bleeding	☐ Skin disease or skin problem
☐ Chronic Cough	☐ Hepatitis or other liver disease	☐ Sleep Apnea
☐ Chronic Pain	☐ Hernia	☐ Stroke
☐ CKD/Renal Disease	☐ High Cholesterol	☐ Suicide attempt
☐ Colon Polyps	☐ Hip Fracture	☐ Thyroid disorders
☐ Congestive Heart Failure	☐ HIV/AIDS	☐ Tuberculosis or + TB Test
☐ Coronary Artery Disease	☐ Hypertension/ High Blood Pressure	☐ Vision Problems or Blindness
☐ COPD or Emphysema	☐ Insomnia	☐ Vitamin B12 deficiency
☐ Crohn's or Ulcerative Colitis	☐ Kidney Stones	☐ Vitamin D deficiency
☐ Other (please specify):		

HOSPITALIZATIONS

Have you been hospitalized within the past year? ☐ Yes ☐ No

***If Yes,** please give details of your hospitalization:*

Hospital (Name and Location)	Reason for Hospitalization	Dates of Stay

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SURGERIES

Please list any major surgeries/operations you have had in that past.

Surgery/Procedure	Date

ALLERGIES

Do you have any allergies? ☐ Yes ☐ No

If Yes, please check all that apply:

☐ Anesthesia ☐ Codeine ☐ Latex ☐ Penicillin

☐ Aspirin ☐ Morphine ☐ Iodine ☐ Sulfa

☐ Bee stings / insect bites ☐ Food: _____

Other Allergies:	Reaction:

FAMILY HISTORY

Check the box for any illnesses/conditions in your blood relatives

Illness/Condition	Mother	Father	Sibling	Grandparent	Child
Heart Disease					
High Cholesterol					
Stroke					
Cancer					
Diabetes					
High Blood Pressure					
Alcoholism					
Liver Disease					
Depression or Psychiatric Illness					
Check if Deceased					

Any other family history worth noting:

HEALTH MAINTENANCE

Please check the box for any vaccinations you have received and list date received

Vaccine	Check if Received	Date Received (Month and Year)	Who/Where Administered?
Flu	☐	____ / ____	
Pneumococcal (Pneumonia)	☐	____ / ____	
Hepatitis B	☐	____ / ____	
Shingles	☐	____ / ____	
Tetanus	☐	____ / ____	

Do you have an Advance Directive or Living Will? ☐ Yes ☐ No ☐ Unsure

If No, would you like to discuss who may speak for your health if you cannot? ☐ Yes ☐ No ☐ Unsure

If Yes, please list who will make medical decisions for you: _____

Relationship: _____ Is this person aware of their role? ☐ Yes ☐ No ☐ Unsure

Have you provided a copy of your Advance Directive to your doctor? ☐ Yes ☐ No ☐ Unsure

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HEALTH MAINTENANCE (cont.)

Please Indicate Month and Year for all Dates Requested

Have you had a colonoscopy or sigmoidoscopy? ☐ Yes ☐ No If yes, date received: _____ / _____

Received Where? _____

Other colon cancer screening? (circle one) Stool Card FIT-DNA Cologuard

Date received: _____ / _____

Have you had a mammogram? ☐ Yes ☐ No If yes, date received: _____ / _____

Results: ☐ Normal ☐ Abnormal

Received Where? _____

Have you had an Eye Exam in the past 2 years? ☐ Yes ☐ No If yes, date received: _____ / _____

Name of your Eye Doctor: _____ Results: ☐ Normal ☐ Abnormal

FUNCTIONAL ABILITY

How is your vision: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Blind

Vision Problems: ☐ Uses Glasses ☐ Uses Contacts

☐ Cataract(s) ☐ Glaucoma ☐ Macular Degeneration ☐ Diabetic Retinopathy

How is your hearing: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Deaf

Do you Use Hearing Aids/Devices? ☐ Yes ☐ No ☐ Left ☐ Right ☐ Both

Do you have trouble hearing friends or family members in regular conversations? ☐ Yes ☐ No ☐ Sometimes

Do you find it difficult to hear the TV, radio, or telephone? ☐ Yes ☐ No ☐ Sometimes

Do you or your family members have concerns about your memory? ☐ Yes ☐ No

Has a doctor ever told you that you have early onset Dementia or Alzheimer's? ☐ Yes ☐ No

Do you have chronic pain? ☐ Yes ☐ No Pain level today: (0 = no pain, 10 = most pain) _____

Current Pain Management Plan: ☐ Medication ☐ Pain Clinic: _____

☐ No Plan ☐ Other: _____

HOME SAFETY

Does your home have working smoke detectors? ☐ Yes ☐ No

Does your home have grab bars, hand railings, and other assistance devices? ☐ Yes ☐ No

Are there loose rugs, small pets, extension cords, or other trip hazards in your home? ☐ Yes ☐ No

Do you have a Life-Alert System (necklace button, bathroom pull-cord, etc.)? ☐ Yes ☐ No

If you drive, have you had any accidents or episodes of becoming lost/disoriented in the past year? ☐ Yes ☐ No

If you drive, do you wear a seatbelt? ☐ Yes ☐ No

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FALL RISK SCREENING

Have you fallen 2 or more times in the past 12 months?	☐ Yes	☐ No
Have you been injured in a fall in the past 12 months?	☐ Yes	☐ No

If you answered "Yes" to either of these questions, please complete the following questions.
If you answered "No" to BOTH questions, please go to the NEXT PAGE.

☐ Yes ☐ No 1) Have you fallen before or been injured because of a fall?

☐ Yes ☐ No 2) Do you feel weaker than you used to or have less strength in your arms and legs?

☐ Yes ☐ No 3) Have you stopped doing daily activities or avoided exercise because you're afraid of falling?

☐ Yes ☐ No 4) Do you feel unsteady on your feet or shuffle when you walk?

☐ Yes ☐ No 5) Has your hand strength decreased?

☐ Yes ☐ No 6) Has your eyesight diminished or do you have trouble seeing depth or seeing at night?

☐ Yes ☐ No 7) Do you feel dizzy when you stand up?

☐ Yes ☐ No 8) Have you experienced hearing or vision loss?

☐ Yes ☐ No 9) Do you have foot ulcers, bunions, hammertoes or callouses that hurt or cause you to adjust your steps?

☐ Yes ☐ No 10) Do you experience incontinence? Bowel or Bladder? (circle one or both)

☐ Yes ☐ No 11) Do you currently use a cane or walker or have you ever been told you should?

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DEPRESSION SCREENING

During the past four weeks, have you often been bothered by any of the following problems?

1) Feeling down, depressed, irritable or hopeless? ☐ Yes ☐ No

2) Little interest or pleasure in doing things? ☐ Yes ☐ No

If you answered "Yes" to either of these questions, please complete the following questions.
If you answered "No" to BOTH questions, you may STOP here.

Over the last 4 weeks, how often have you been bothered by any of the following?	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 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 of hurting yourself in some way	0	1	2	3
	PHQ Total Score (office use only)			

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THIS PAGE TO BE COMPLETED BY MEDICAL STAFF

VITAL SIGNS & MEDICATIONS

Height: _____ Weight: _____ BMI: _____ ☐ Underweight (< 18.5)

☐ Normal (18.5 - 24)

☐ Overweight (24- < 30)

☐ Obese (> 30)

Blood pressure: _____ / _____ (if value is > 140/90, repeat at end of visit)

Date of last HgbA1C: _____ Value: _____

Does patient have diagnosed diabetes mellitus? ☐ Yes ☐ No Type: ☐ I ☐ II

Date of last Lipid Panel: _____ HDL: _____ LDL: _____

☐ Current Medications Reviewed and Reconciled with Patient today

*** Full Medication List required to be documented in chart today ***

Notable changes/updates to medications: _____

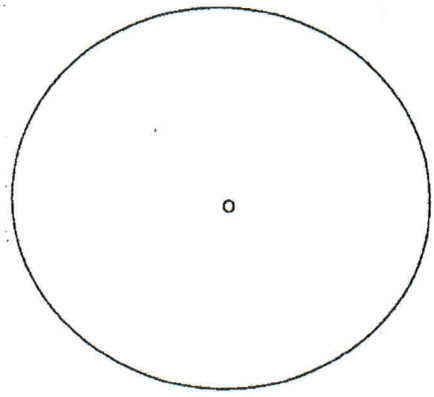
_____

Is patient taking aspirin or antithrombotics? ☐ Yes ☐ No

Is patient taking a statin? ☐ Yes ☐ No

COGNATIVE & GAIT ASSESSMENT

1. Ask the patient to remember three words: Banana, Nickel, Chair.
2. Observe gait: Ask patient to stand, walk across the room and back, and sit down. If they can do this in 20 seconds, gait is probably OK. Is gait normal? ☐ Yes ☐ No
3. Ask to recall the words from Question 1. Recalled: ☐ 0/3 ☐ 1/3 ☐ 2/3 ☐ 3/3
4. Ask patient to draw the hands on the clock at 9:00. Draw a clock OK? ☐ Yes ☐ No
5. Do patient's family members/caregivers have concerns about the patient's cognition or gait?



Medical Professional to complete the Personalized Prevention Plan on the following page, then check and sign below:

☐ **Areas of concern within the Annual Wellness Visit have been addressed, counseling has been offered, and a Personalized Prevention Plan has been covered with patient.**

Signature & Title: _____ Date: _____

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PERSONALIZED PREVENTION PLAN

Based on the results of your Annual Wellness Visit with Dr. _____

on _____, **the following has been recommended for you:**

Preventive Health	Counseling
☐ Mammogram (every 2 yrs age 50-74)	☐ Nutrition / Healthy Eating
☐ Bone Density scan (routinely as needed)	☐ Weight Loss
☐ Colonoscopy (every 10 yrs after age 50)	☐ Diabetic Meal Planning
☐ Flu shot (annually Sept. - March)	☐ Other Special Diet _____
☐ Pneumonia shot (1-2 doses up to age 64, 1 dose age 65+)	☐ Physical Activity / Exercise
☐ Shingles vaccine (once/lifetime)	☐ Depression / Mental Health
☐ Other vaccination: _____	☐ Smoking Cessation
☐ Blood work:	☐ Alcohol Abuse
☐ Cholesterol (routinely)	☐ Drug Abuse
☐ Hemoglobin A1C (every 6 mo. for diabetics)	☐ Pain Management
☐ CBC (complete blood count) (routinely)	☐ Fall Prevention / Safety at Home
☐ Other _____	☐ Advance Directive
☐ PSA (annually after age 50)	☐ Other _____
☐ Pelvic Exam/Pap (every 3-5 yrs to age 65)	
☐ Vision check (every 1-2 yrs)	
☐ Other _____	

Additional Notes or Recommendations:

If you have any other questions about your health, please be sure to speak with your Healthcare Provider.
We hope you were satisfied with your Annual Wellness Visit and Wellness Plan.

Please schedule next year's Annual Wellness Visit so that we may keep your health information up to date.

{Provider, please place copy in medical record before giving to patient}

Living Will

Declaration made this _____ day of _____, 2____, I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(initial) I have a terminal condition,
or _____(initial) I have an end-stage condition,
or _____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____
Street Address _____
City _____ State _____ Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____
_____
_____
_____
_____

(Signed) _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

At least one witness must not be a husband or wife or a blood relative of the principal.

Medicare Patient Chronic Care Management Program

We would like to offer you a program at this doctor's office that will help us work together to improve your health. A lot goes on at times other than during your office visits. People on your health team work with each other and with you on the phone, on your medical record system and in person. This helps you in many ways. For example it keeps your medicine list, tests that you need, and other services well organized and updated.

Medicare and your doctors know how to keep you healthy.

Taking part in the Chronic Care Management Program is optional and up to you to decide.

I agree that I have read and understand all of the above information. By signing below I agree that I want to take part in the Medicare Chronic Care Management Program.

All my questions have been answered and If I had any questions I can call doctor office and get answered. I understand I do not have to sign this or take part in this program. It is voluntary, I also answer that I am the patient or have authorized someone to sign for me.

I can decide at any time to stop taking part in that program.

Signature of Responsible Party _____ Date _____ Relation to Patient _____