Medicare Wellness Visit

(Welcome to Medicare, Annual and Subsequent Visits)

Patient Name: _____ **DOB:** _____

1. **Do you have little interest or pleasure in doing things?**
   ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Declined to specify
2. **Have you been feeling down, depressed, or hopeless?**
   ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Declined to specify
3. **Please list other physicians or health care providers involved in your health care, including Vision, Dental and Home Health providers?** ☐ **I have no other physician or health care provider involved in my health care.**
   If applicable list Name/Specialty below.

   _____ _____ _____

   _____ _____ _____
4. **What company provides your medical supplies? (Diabetes supplies, respiratory supplies, medical equipment, other).** ☐ **N/A**

   _____ _____ _____
5. **Are you having difficulties driving your car?** Yes, often Sometimes No N/A, I do not drive
6. **Do you wear a seat belt when in your car?** Yes, usually Yes, sometimes No
7. **Are you afraid of falling?** Yes No
8. **Does your home have rugs in hallways?** Yes No
9. **Does your home lack handrails on the stairs or grab bars in the bath/shower?** Yes No
10. **Does your home have poor lighting?** Yes No
11. **How often do you have trouble taking your medication as directed?**
    ☐ N/A, I do not take medication ☐ I always take them as prescribed
    ☐ Sometimes I take them as prescribed ☐ Seldom do I take them as prescribed
12. **Do you have trouble affording or filling your medications?** Yes No
13. **Can you handle your own money without help?** Yes No
14. **Can you get places out of walking distance without help?** Yes No
15. **Can you shop for groceries or clothes without help**? Yes No
16. **Can you do housework without help?** Yes No
17. **Do you need personal care help such as eating, bathing, dressing or getting around the house due to health problems?** Yes No
18. **Do you exercise for about 20 minutes three or more times a week?** Yes No
19. **During the past month, have you experienced body pain?**
    ☐ No pain ☐ Very Mild Pain ☐ Mild Pain ☐ Moderate Pain ☐ Severe Pain

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20. During the past month, have you experienced leaking of urine or other difficulties with incontinence?

☐ No difficulties ☐ Occasional difficulties ☐ Frequent difficulties

21. During the past month, have you been able to find available help for physical or emotional help when you needed or wanted help?

☐ Yes, as much as I want ☐ Yes, quite a bit ☐ Yes, some

☐ Yes, a little ☐ No, not at all

22. During the past month, have you experienced falling or dizziness when standing up?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

23. During the past month, have you experienced any sexual problems?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

24. During the past month, have you had trouble eating well?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

25. During the past month, have you experienced any teeth or denture problems?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

26. During the past month, have you experienced problems using the telephone?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

27. During the past month, have you experienced tiredness or fatigue?

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

28. How many alcoholic drinks do you consume per week (wine, beer, other alcohol beverage)?

☐ 10+ ☐ 6-8 ☐ 2-5 ☐ 1 or less ☐ No alcohol at all

29. Rate your health in general.

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

FOR THE MEDICAL PROVIDER

PROVIDER

- Medical and Family History
- Social History *(alcohol, drug, diet, exercise)*
- Cognitive Impairment
- Problem List
- Physical Exam (as indicated)
- Annual Preventive Counseling and Personalized Health Plan (Preventive Medicine)
- G0438 Second Year
- G0439 Subsequent Annual Visits

STAFF

- Current Medications
- Social History *(tobacco*)
- Hearing Screening (vitals)
- Vision Screening (vitals)
- Fall Screening (preventive medicine)
- Immunizations
- Scan Form. Enter above in ROS
- Print Visit Summary
- **Check for Lab ABN to be Signed**