Name_____Date of Birth_____ Today's Date_____

Welcome to your Medicare Wellness Visit-It's Not Just a Physical Anymore!

We are looking forward to seeing you at your upcoming Medicare Wellness visit, where we will focus on creating a **wellness plan** customized for you.

Before your visit:
We want to spend our time together to focus on what is most important to you. Please complete the questionnaire below and bring it with you on the day of your visit so we spend less time collecting information and more time on what matters!

On the day of your visit:

- Be sure to bring your valid insurance card with you.
- Blood tests: If you plan to have fasting blood work for cholesterol or blood sugar, please come fasting: no food for 10 hours prior to your appointment, but drink plenty of water or non-caloric drinks (black coffee or tea are fine!). Take your medications as usual.
- Urine sample: you may be asked for a urine sample at the office.
- If you must cancel your appointment, please let us know at least 24 hours in advance.
- Please bring a list of your medications, or bring the medications themselves! Include all over the counter products you take.

Is my wellness visit covered by Medicare?
Yes! Medicare covers your wellness visit with your primary care doctor once every 365 days to be sure you can create and follow your own Wellness Plan. There is no co-pay or deductible for these visits.

A **preventive or "well" visit** focuses on staying as healthy as possible. Medical problems like pains, fatigue, constipation, diabetes, heart problems, lung problems etc. are addressed at **sick or disease management visits**. These problems require a different history, review of past treatments, lab tests and x-rays, and medication management.

If we combine a problem visit with your well visit, we will submit the appropriate codes and charges to your insurance company for both the well visit and the problem visit. This is the correct and accepted way to bill for this type of appointment. Depending on your insurance plan, you may be responsible for a portion of the bill.

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Medicare Wellness Visit Patient Questionnaire

Please complete this questionnaire before your visit and bring it with you along with all of your current medications.

How have you been feeling?

In the past two weeks:	Not at All	Several Days	More than half the days	Nearly every day
Have you been bothered by little pleasure in doing things?				
Have you been bothered by feeling down depressed or hopeless?				
Trouble falling or staying asleep, or sleeping too much?				
Do you feel tired or have too little energy?				
Poor appetite or overeating?				
Feeling bad about yourself or that you are a failure or have let yourself or your family down?				
Trouble concentrating on things, such as reading the newspaper or watching television?				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual?				
Thoughts that you would be better off dead, or of hurting yourself?				

	Hardly Ever	Sometimes	Often
How often is stress a problem for you in handling your health, finances, family or social relationships?			
In the past 7 days, how often have you felt angry?			
How often do you feel you lack companionship?			
How often do you feel left out?			
How often do you feel isolated from others?			
In the past 7 days, how much pain have you felt?			

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	No	Yes
Do you have concerns about your memory?		
Have family or friends been concerned about your memory?		
Do you have concerns about sex?		
Do you have problems with your teeth or gums?		
Do you have dentures?		
Do you see a dentist?		
Does anyone have concerns about your hearing?		

Vitamins- check the ones you take

	None		Vitamin D
	Calcium		Other:
	Multi-vitamin		

Diet

- How many fruits and vegetables do you eat on most days? _____
- How many fried foods do you eat on most days? _____
- How many 8 oz. glasses of fruit juice or sweetened beverages do you drink on most days? _____

Functioning at Home

	Able to	Not able to	Find it difficult to
Dress yourself			
Feed yourself			
Toilet yourself			
Groom yourself			
Bathe yourself			
Handle your finances			
Obtain and take your medicines			
Get in and out of a car			
Walk 1-4 blocks			
Walk 5-9 blocks			
Walk 10 or more blocks			
Go down steps			
Go up steps			
Kneel			
Put on socks and shoes			
Shop for yourself			
Prepare your own food			
Do your housekeeping			
Do your laundry			
Use a telephone			

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What transportation do you use? _____
(for example: taxi, drive your car, family drives you, friend drives you, etc.)

Home Safety

	No	Yes
Do you have smoke detectors in your home?		
Do you have firearms in your home?		
Do you use a seat belt when in a vehicle?		

Falls

	No	Yes
Did you fall in the last year?		
If so, did the fall(s) result in injury?		
Do you use a cane or walker?		
Do you have trouble with balance?		

- How frequently do you exercise? 2-3 times per week / 3-4 times per week / Daily / Occasionally / Never
- What do you do for exercise? _____

Alcohol

- How many alcoholic drinks* do you have per week? _____
  (*one drink = 12 ounces of beer, 5 ounces of wine or 1.5 ounces of 80 proof liquor)
- On days when you drank alcohol, how often did you have (4 for men, 3 for women) alcoholic drinks on one occasion? *Circle one:* Never / Occasionally / once per month / once or more per week
- Do you ever drive after drinking, or ride with a driver who has been drinking? No Yes

Tobacco and Vaping

	No	Yes	If yes, what kind?	If yes, number per day?	Former User- age when quit
Do you use tobacco?					
Do you vape or use electronic cigarettes?					

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Other Medications

	No	Yes
Do you take opioids (narcotics)?		
Do you take drugs you obtained elsewhere?		

Medical History Update

	No	Yes	Details if Yes
Illnesses since last visit			
Injuries since last visit			
Hospital stays since last visit			
Specialists since last visit			
Operations since last visit			

Family History Update

Write new health problems since your last visit for your:

- ☐ Parents _____
- ☐ Sisters and brothers _____ ____No sisters or brothers
- ☐ Children _____ ____No children

Provider List

- If this is your first Medicare Wellness visit, please list the providers who care for you.
- If this is not your first Medicare Wellness visit, please list new providers since your last visit.
- Please include doctors and other suppliers of care like personal care assistant, home health aide, adult day care, home delivered meals, etc.

Provider Name	Provider Location	Provider Phone

Advance Care Planning *(See below for more details)*

	No	Yes*	Don't Know
Do you have an advance directive or living will?			
Do you have a healthcare proxy or surrogate decision maker?			

**If yes, Please bring a copy for your chart!*

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Advance Directive Explanation

An advance directive is an important legal document for all adults to have. It serves as a guide for your family and healthcare team to follow if a life-threatening event were to happen. Developing a guide keeps you in charge when it comes to decisions about medical treatment—even when you're no longer capable of making those decisions. This kind of planning also shows compassion for family and friends. When loved ones are left guessing, too often the result is guilt, uncertainty, and arguments. By making your wishes known, you can help your loved ones feel more comfortable with your chosen course of care..

- An advance directive, also known as a living will, tells medical professionals and your family which medical treatments you want to receive or refuse—and under what conditions. It only goes into effect if you meet specific medical criteria and are unable to make decisions.
- A healthcare proxy, also known as surrogate decision maker or health care power of attorney, allows you to appoint someone to make healthcare decisions for you any time you're unable to do so. Most people choose trusted family members or friends who are comfortable talking to doctors. This is different from a regular power of attorney, which only covers financial matters.

If you have an advance directive or have assigned a healthcare proxy, our office would like to have a copy of that information in your health record.

If you do not have an advance directive, we have enclosed blank copies of an advance directive and declaration of a healthcare proxy. Please consider completing these forms to help those you care about know your wishes. These forms do not require notarization but do require 2 witnesses to become legal documents.

_____ _____ _____

Provider signature Date Time

4.22.20