*Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,*

# *Your Appointment for the*  *Welcome to Medicare Visit OR* *Annual Wellness Visit is scheduled on\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_*

***There is NO CO-PAY*** *for this visit, so it is free for you.*

*The goal of this visit is to provide time for you to discuss with your doctor, areas of your health that may put you at risk for problems in the future.*

*As part of the visit, you will be screened for fall risk, safety risk, worsening memory, depression and other medical concerns.*

***This is NOT a “full physical”,*** *but a time to review your medical history and make certain that appropriate screening tests have been performed.*

*During a wellness visit under Medicare, patients will have the chance to discuss any changes to existing conditions that have previously been documented, and the physician will review medical history to ensure that the patient is still in need of any prescribed medications.*

*Additionally, a cognitive assessment is typically performed during the wellness visit, but this is usually done simply by conversing in the office. Finally, patients will fill out a wellness questionnaire while waiting to see the doctor, and the answers will be assessed to ensure that the doctor is able to address any symptoms that are deemed problematic that may not have been expressed directly by the patient.*

*In order to help the visit run smoothly, please complete the* ***enclosed forms and bring them with you to your visit.*** *Try to complete as much as you can before your appointment. The information will help you and your doctor better understand what screenings you should get and what to watch for in the future.*

*Please make sure to be on time and call with more than 24 hours’ notice if you cannot make your appointment.*

*If you have questions regarding this visit, please call our office.*

*We look forward to seeing you soon.*

#  MEDICARE WELLNESS VISIT

***Please complete this questionnaire as thoroughly as possible. This confidential history will be part of your permanent records and will help us get a better understanding of your overall health. THANK YOU!***

**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_ Social History** ✓ **all that apply:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Tobacco Use:**  | * **Cigarettes**
* **Chew**
* **Cigars**
* **Snuff**
* **2nd hand**
 |  **Never**  |  **Prior use**  |  **Quit Date: \_\_\_\_\_\_\_\_\_\_\_**  |
|  **Frequency: \_\_\_\_ cigs/packs day/week # of yrs: \_\_\_\_\_\_\_\_\_\_**  **Are you interested in quitting?**  **Yes**  **No**  |
|   |
| **Alcohol:**  **Never**  **Occasional**  **Daily**  |
| **Caffeine:**   **Never**  **Occasional**  **Daily**  |
| **Drug’s:**  **Never**  **Occasional**  **Daily**  **Prior Quit Date:** **\_\_\_\_\_\_\_\_\_**  |
| **Occupation:**   | **Retired?** **Yes** **No** |
| **Home Environment:**  **Private home**  **Assisted living**  |  **Other: (describe)**  |

## Family History – use ✓ to indicate positive history

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|   | **Self**  | **Father**  | **Mother**  | **Brothers**  | **Sisters**  | **Aunts**  | **Uncles**  | **Daughters**  | **Sons**  |
| **Deceased**  |   |   |   |   |   |   |   |   |   |
| **Hypertension**  |   |   |   |   |   |   |   |   |   |
| **Heart disease**  |   |   |   |   |   |   |   |   |   |
| **Stroke**  |   |   |   |   |   |   |   |   |   |
| **Kidney Disease**  |   |   |   |   |   |   |   |   |   |
| **Obesity**  |   |   |   |   |   |   |   |   |   |
| **Genetic disorder**  |   |   |   |   |   |   |   |   |   |
| **Alcoholism**  |   |   |   |   |   |   |   |   |   |
| **Liver disease**  |   |   |   |   |   |   |   |   |   |
| **Depression**  |   |   |   |   |   |   |   |   |   |
| **Colon cancer**  |   |   |   |   |   |   |   |   |   |
| **Breast cancer**  |   |   |   |   |   |   |   |   |   |
| **Other Cancer**  |   |   |   |   |   |   |   |   |   |
| **Other:**  |   |   |   |   |   |   |   |   |   |

***NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT SECTION***

**Have had any reecent Hospital Visits?**  **NO** **YES *If yes*:**

|  |  |  |
| --- | --- | --- |
| **Reason**  | **Date**  | **Where**  |
|  |  |  |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |

**Have you had any recent Surgeries?**  **NO**  **YES *If yes:***

|  |  |  |
| --- | --- | --- |
| **Type/Reason**  | **Date**  | **Where**  |
|  |  |  |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |

**Do you have any Allergies:**  **NO** **YES *If yes:***

|  |  |
| --- | --- |
| **Allergy to what?**  | **What type of reaction?**  |
|   |   |
|   |   |
|   |   |

**Please list NEW medications, including VITAMINS, HERBS, OVER THE COUNTER MEDICATIONS and SUPPLEMENTS**

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICATION OR SUPPLEMENT**  | **DOSE, HOW** **MANY** **TIMES A DAY**  | **MEDICATION OR SUPPLEMENT**  | **DOSE, HOW** **MANY** **TIMES A DAY**  |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

***NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT SECTION***

**Please list any Acute or New medical problems (will not be discussed in full today)**

|  |  |  |
| --- | --- | --- |
|  **MEDICAL CONDITION**  | **DOCTOR WHO MANAGES**  | **How long has this been going on?**  |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |

**Please list all other providers that you see; please include therapists, chiropractors, acupuncturists, nutritionists, etc:**

|  |  |
| --- | --- |
| **PROVIDERS NAME**  | **What do you see them for?**  |
|   |   |
|   |   |
|   |   |
|   |   |
|   |   |
|   |   |

|  |  |  |
| --- | --- | --- |
| **HEARING SCREENING:** |  **Yes**  |  **No**  |
| **Do you have a problem hearing the telephone?**  |  |  |
| **Do you have trouble hearing the television or radio**  |  |  |
| **Do people complain that you turn the TV volume up too high?**  |  |  |
| **Do you have to strain to understand conversation?**  |  |  |
| **Do you find yourself asking people to repeat themselves?**  |  |  |
| **Do many people you talk to seem to mumble (or not speak clearly)?**  |  |  |

***NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ PATIENT SECTION***

|  |  |  |  |
| --- | --- | --- | --- |
| **BALANCE/ SAFETY/ FALL SCREENING**  | **Yes**  |  **No**  | **Some Times**  |
| **Do you live alone?**  |  |  |  |
| **Does your home have rugs in the hallway?**  |  |  |  |
| **Do you keep your hallway well-lit even at night?** |  |  |  |
| **Do you need help with the phone, transportation, shopping, meals, housework, laundry**  |  |  |  |
| **Does your home have grab bars in bathrooms, handrails on stairs and steps?**  |  |  |  |
| **Does your home have functioning smoke alarms?**  |  |  |  |
| **Do you experience any dizziness or imbalance?** |  |  |  |
| **Does bending over increase dizziness or imbalance?**  |  |  |  |
| **Do you restrict travel for business/recreation due to your imbalance?**  |  |  |  |
| **Are you afraid to leave the house alone due to dizziness or imbalance problems?**  |  |  |  |
| **Have you fallen in the past year?**  |  |  |  |
|  **EXERCISE**  |
|  **How many days a week do you usually exercise? \_\_\_\_\_\_\_\_ days per week**  |
|  **On days when you exercise, for how long do you usually exercise? \_\_\_\_\_\_ minutes per day** Does not apply |
|  **How intense is your typical exercise? (check one)** I am currently notexercising  **Light**(like stretching or slow walking) **Moderate** (like brisk walking) **Heavy** (like jogging or swimming **Very heavy** (like fast running or stair climbing) |
| **NUTRITION**  |
| **Are you on a special diet?** YesNo*If yes, why?* |
| **On a typical day, how many servings of fruits and/or vegetables do you eat? \_\_\_\_\_\_\_\_ servings per day** (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit, 1 cup = size of a baseball)  |
| **On a typical day, how many servings of high fiber or whole grain foods do you eat? \_\_\_\_\_\_ servings per day** **(**1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal,½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta**)**  |
| **On a typical day, how many servings of fried or high-fat foods do you eat? \_\_\_\_\_\_ servings per day** **(**Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise) |
| **MOTOR VEHICLE SAFETY**  |
| **Do you always fasten your seat belt when you are in the car?** YesNo**Do you ever drive after drinking, or ride with a driver who has been drinking?** **Y**es No |
| **SUN EXPOSURE**  |
| **Do you protect yourself from the sun when you are outdoors?** YesNo  |

***NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ PATIENT SECTION***

|  |
| --- |
| **GENERAL WELL-BEING**  |
| **How often is stress a problem for you?**  | Never/rarely  | Sometimes  | Often  | Always  |
| **How well do you handle the stress in your life?**  | I’m usually able to cope effectively  | At times I have problems coping  | I often have problems coping  |   |
| **How many hours of sleep do you usually get each night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |
| **In general, would you say your health is:**  | Excellent  | Very good  | Good  | Fair  | Poor  |
| **How often do you get the social and emotional support you need:**  | Always  | Usually  | Sometimes  | Rarely  | Never  |
| **In general, how satisfied are you with your life:**   | Very satisfied  | Satisfied  | Dissatisfied  | Very dissatisfied  |   |
| **DEPRESSION SCREENING: PHQ-9**  |
| **Over the last 2 weeks, how often have you been bothered by any of the following:** ***(Check the appropriate box to the right)***  |  **(0) Not at**  **all**  |  **(1)**  **Several**  **Days**  |  **(2)**  **More than half the days**  |  **(3)**  **Nearly every day**  |
| **1. Little interest or pleasure in doing things**  |  |  |  |  |
| **2. Feeling down, depressed, or hopeless.**  |  |  |  |  |
| **3. Trouble falling/staying asleep, sleep too much.**  |  |  |  |  |
| **4. Feeling tired or having little energy.**  |  |  |  |  |
| **5. Poor appetite or overeating.**  |  |  |  |  |
| **6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.**  |  |  |  |  |
| **7. Trouble concentrating on things, such as reading the newspaper or watching television.**  |  |  |  |  |
| **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.**  |  |  |  |  |
| **9.Thoughts that you would be better off dead or of hurting yourself in some way.**  |  |  |  |  |

 ***NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ PATIENT SECTION***

|  |
| --- |
| **Anxiety Screening GAD 7**  |
| **Over the last 2 weeks, how often have you been bothered by any of the following:** ***(Check the appropriate box to the right)***  |  **(0) Not at**  **all**  |  **(1)**  **Several**  **Days**  |  **(2)**  **More than half the days**  |  **(3)**  **Nearly every day**  |
| **1. Feeling nervous anxious or on edge**  |  |  |  |  |
| **2. Not being able to stop or control worrying**  |  |  |  |  |
| **3. Worrying too much about different things**  |  |  |  |  |
| **4. Trouble relaxing**  |  |  |  |  |
| **5. Being so restless that is is hard to sit still**  |  |  |  |  |
| **6. Becoming easily annoyed or irritable**  |  |  |  |  |
| **7. Feeling afraid as if something awful may happen**  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Social Needs Screening Tool** | **Yes** | **No** |
| **In the last 12 months did you eat less food than you felt like you should because there was not enough money for food?** |  |  |
| **In the last 12 months did the gas, water, or electric company threaten to shut off services to your home?** |  |  |
| **Are you worries in the next 3 months you will not have stable housing?** |  |  |
| **Have you needed to see the doctor but did not due to the cost?** |  |  |
| **Have you needed to see the doctor nut did not due to transportation?** |  |  |
| **Do you need help reading hospital materials?** |  |  |
| **Do you often feel a lack oof companionship?** |  |  |
| **Have you gone without your prescriptions due to the cost?** |  |  |
| **Does anyone in your life threaten you with harm or physically harm you?** |  |  |

Maryland Primary Care Program - SBIRT Screening

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Question |  |  | Scoring System | YourScore |
|  | 1 | 2 | 3 | 4 |
|  | Never | Monthly of less | 2-4 times per month | 2-3 times per week | 4+ times per week |  |
| How often do you have a drink containing alcohol? |  |  |  |  |  |  |
| How many units of alcohol do you drink on a typical day when you are drinking? |  |  |  |  |  |  |
| How often have you had 6 or more units if female, for male 8 or more units on a single occasion in the last year? |  |  |  |  |  |  |
|  |  |  | Total Score\* |  |



|  |  |  |
| --- | --- | --- |
| 1. In the last 12 months, did you use any illicit drugs? | Yes | No |
| 2. In the last 12 months, did you misuse any prescription medication? | Yes | No |

3. if yes to either of the previous questions, what drugs did you use in the last 12 months