Manatee
Physician Alliance

Name: _____

Date of Birth: _____

Today's Date: _____

Medicare Wellness Visit

Dear Patient,

Your Medicare benefits include an Annual Wellness Visit to assist in preventing illness or detect illness at an early stage. Your Annual Wellness Visit is a free benefit from Medicare. During this visit, the provider will:

- **Concentrate on preventative medicine.**
- **Focus on identifying factors that may represent risk for further medical problems. The provider will work with you to reduce these risks.**
- **Review your medical history, medications, and confirm the names of any other medical providers you see.**
- **Work with you to establish a personal prevention plan in an effort to prevent or identify medical problems.**

**** This wellness visit is provided without any cost to you, but does not include the cost of medical treatment and is not the same as an "annual physical exam". If medical treatment is provided, your insurance may require an office co-pay be applied to the visit. 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:

Date	Date
Colonoscopy	Mammogram
Cholesterol	Pap Smear
PSA	Dexa (Bone Density)
Glaucoma Screening	Abdominal Aortic Aneurysm Screening

Immunizations:

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

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

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Medicare Wellness Visit: Health Risk Assessment

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
8. In the past four weeks, how many drinks of wine, beer or other alcoholic beverages did you have?
   - ☐ 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

   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
10. 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
11. Do you eat three meals a day?
    - ☐ Yes
    - ☐ No:_____
12. How many servings of fruits and vegetables do you eat on a typical day?

    _____ servings per day
13. How many servings of high fiber or whole grains do you eat on a typical day?

    _____ servings per day

_____

Provider Signature /

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

20. 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
21. In the past four weeks, 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
22. In the past four weeks has your physical or emotional health limited your activities with your family or friends?
    ☐ Yes
    ☐ No
23. 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: _____
24. Are you having any problems with your memory?
    ☐ Yes
    ☐ No
25. 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
26. How many hours do you sleep on a typical night?
    _____ hours each night
27. Do you awaken at night?
    ☐ Yes
    ☐ No
28. Are there any hazards in your home that might hurt you; loose rugs, poor lighting?
    ☐ Yes
    ☐ No
29. Have you fallen two or more times in the past year?
    ☐ Yes
    ☐ No
30. Are you afraid of falling or have balance problems?
    ☐ Yes
    ☐ No
31. 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
32. Are you having any difficulty driving your car?
    ☐ Yes, often
    ☐ Sometimes
    ☐ None
    ☐ I do not drive a car
33. Do you wear your seatbelt when you are in the car?
    ☐ Always
    ☐ Usually
    ☐ Never
34. Do you wear sun screen, sun glasses, protective clothing when out in the sun?
    ☐ Yes
    ☐ No
35. 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

_____
Provider Signature /

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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?

(*Circle 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 _____

(*Circle your answer once again)*

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.	Not at all difficult	Somewhat difficult	Very difficult	Extremely difficult

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

_____

Provider Signature / Date