Medicare Annual Wellness Visit-

(updated Jul 2019)

The purpose of this visit is to review and update your medical history and assess risk factors that may affect your health or safety. If problems are addressed during this visit, those services may be billed separately.

TODAY'S DATE: _____ **NAME:** _____ **Date of Birth:** _____

Part of your annual wellness visit for Medicare requires us to collect your race and ethnicity in order to best assess your health status and risk factors.

RACE: ☐ White ☐ African-American ☐ Asian ☐ _____

ETHNICITY ☐ Hispanic ☐ Non-Hispanic ☐ I prefer not to respond

HEALTHCARE PROVIDERS: Please provide the names of your current healthcare providers for the following specialties:

Allergist/ENT: _____

Cardiologist: _____

Dentist: _____

Dermatology: _____

Endocrinology: _____

Gastroenterology: _____

General Surgery: _____

Gynecology: _____

Other: _____

Cancer doctor: _____

Eye doctor: _____

Orthopedic Surgeon: _____

Pain Management: _____

Podiatrist: _____

Psychiatrist: _____

Pulmonologist: _____

Urology: _____

Other: _____

MEDICATIONS: Please provide the names & doses of your current medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ACTIVITIES OF DAILY LIVING

1. Can you use the telephone? ☐Yes without help ☐ Yes with help ☐No
2. Do you drive? ☐Yes ☐ Yes (day-time only or limited) ☐No
3. Can you go shopping for groceries? ☐Yes without help ☐ Yes with help ☐No
4. Can you prepare meals? ☐Yes without help ☐ Yes with help ☐No
5. Do you do your own housework? ☐Yes without help ☐ Yes with help ☐No
6. Do you take your own medications? ☐Yes without help ☐ Yes with help ☐No
7. Are you able to manage your own finances? ☐Yes without help ☐ Yes with help ☐No
8. Are you able to dress and groom yourself? ☐Yes without help ☐ Yes with help ☐No
9. Are you able to feed yourself? ☐Yes without help ☐ Yes with help ☐No
10. Are you able to use the restroom yourself? ☐Yes without help ☐ Yes with help ☐No

Do you feel safe at home? ☐ Y ☐ N ☐ prefer not to answer
(We offer assistance if you are in a relationship where you have felt afraid or have been physically hurt or threatened)
Would you like to discuss your situation with someone who has expertise in these matters? ☐ Y ☐ N

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
☐Very hard ☐ hard ☐somewhat hard ☐not very hard

HEARING

Which of the following best describes your hearing? (Check ONE)
☐Normal ☐Slightly Decreased ☐Significantly Decreased

Do you use a hearing aid?
☐ Yes ☐ No

SELF ASSESSMENT OF HEALTH AND STRENGTH

How would you rate yourself in the following areas?
Overall Health ☐Very Poor ☐ Poor ☐Fair ☐Good ☐Very Good
Strength ☐Very Poor ☐ Poor ☐Fair ☐Good ☐Very Good

HEALTH RISKS AND INJURY PREVENTION

☐ Y ☐ N Do you wear a seatbelt?
☐ Y ☐ N Have you been in a car accident in the last 12 months?
☐ Y ☐ N Does your home have working smoke detectors?
☐ Y ☐ N Do you avoid having slippery floors and/or rugs in your home?
☐ Y ☐ N Do you use the handrails in your home?
☐ Y ☐ N Do you have grab bars in your shower?

SELF ASSESSMENT OF PAIN

Has pain limited your daily activities in the past four weeks? ☐No ☐ a little ☐moderately ☐ a lot

Name_____DOB_____

NUTRITION

How would you describe your current diet? ☐ Well-balanced ☐ Poorly balanced ☐diabetic
☐Weight loss diet ☐Low Cholesterol/low Fat ☐Vegetarian ☐Low Carbohydrate ☐Low Salt
☐Skips Meals ☐other diet_____
☐_____alcoholic drinks per ☐day ☐week ☐month ☐Former heavy user no longer drink alcohol since_____

ORAL HEALTH

Do you see a dentist regularly? ☐ Y ☐ N ☐ N/A (dentures)

EXERCISE

☐ None ☐Infrequently ☐_____ Times Per Week ☐Daily
☐Aerobic Conditioning ☐Swimming ☐Stretching ☐Walking ☐Bicycling ☐Strength Training ☐Running
☐Other (Please describe): _____

Tobacco Use

☐ Never smoker ☐ Former smoker ☐Current smoker ☐e-cigarettes/vaping ☐chewing tobacco user
☐ Thinking about quitting ☐Would like to set a quit date ☐No desire to quit ☐ Wants assistance in quitting

AD-8 Dementia screening (OK to have family member or patient answer)

Please note "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	**Yes, a change**	**No change**	**N/A, don't know**
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. Daily problems with thinking and/or memory			

Fall Risk

☐ Y ☐ N Have you fallen in the last week?
☐ Y ☐ N Have you fallen in the past 12 months?
☐ Y ☐ N Do you feel unsteady on your feet?
☐ Y ☐ N Do you use a cane?
☐ Y ☐ N Do you use a walker?
☐ Y ☐ N Have you participated in balance training in the last 12 months?

BLADDER CONTROL

Do you have any difficulty with urine leaks? ☐Y ☐ N
If so, do you want to talk about it today? ☐Y ☐ N

Advance Directives

Do you have a Medical Power of Attorney? (Someone to make medical decisions for you in the event you are unable to)
☐ Y ☐ N ☐ Don't remember
Do you have a Living Will or Advance Directive? ☐ Y ☐ N ☐ Don't remember
Do you have a DNR (Do Not Resuscitate)? ☐ Y ☐ N ☐ Don't remember
Where can these be found? _____
Would you like assistance in creating either of these documents? ☐ Y ☐ N (If yes our social worker will contact you)

Performed by provider only: Timed Get Up & Go (TUG) optional test for fall risk

The TUG test is performed by observing the time it takes a person to: • Rise from a chair without using arms or armrest support (if possible), • Walk a distance of 3 meters (10 feet), • Turn, • Walk back, and • Sit down again.
[Important items to observe include the person's • Ability to stand, • Steadiness during walking, • Balance while turning, and • Ability to complete the test in less than 20 seconds]
Time to
complete:_____Comments:_____
_____

PROVIDER USE ONLY: Fall risk: ☐Low ☐Medium ☐High

Referred for Bladder Control management	☐ Y	☐ N	☐ N/A	**Pt declined referral ☐**
Referred for Pain control management	☐ Y	☐ N	☐ N/A	**Pt declined referral ☐**
Referred for Balance Training	☐ Y	☐ N	☐ N/A	**Pt declined referral ☐**
Referred for Nutrition Counseling	☐ Y	☐ N	☐ N/A	**Pt declined referral ☐**
Referred for Depression Follow Up	☐ Y	☐ N	☐ N/A	**Pt declined referral ☐**
Tobacco cessation counseling given today	☐ Y	☐ N	☐ N/A	
Social Work Consult	☐ Y	☐ N	☐ N/A	**Pt declined referral ☐**
Referred for Cognitive evaluation	☐ Y	☐ N	☐ N/A	**Pt declined referral ☐**

Reviewed By Initials:_____