MISSION
FAMILY MEDICINE

NAME: _____ DOB: _____ TODAY'S DATE: _____

A WORD TO OUR PATIENTS ABOUT MEDICARE AND WELLNESS CARE

Dear Patient,

In order to allow for greater pricing transparency, we feel it is necessary to clarify the term "wellness care". We want you to receive wellness-care that may lower your risk of illness or injury. Medicare pays for some wellness care, but it does not pay for all the wellness care you may need. We want you to know about your Medicare benefits and maximize their usefulness.

The term "physical" is often used to describe wellness care. However, Medicare **does not** pay for traditional, head to toe physical. Medicare **does** pay for a wellness visit once a year to identify health risks and to help you reduce them.

The Medicare Wellness Visit includes the following assessments:

-Screening to detect depression, risk of falling, cognitive issues, and other problems.

-A measurement of your vital signs however, we will be performing a full exam as we feel that it is important to be diligent and thorough in your care.

-Recommendations for other wellness services and healthy lifestyles changes.

A wellness visit **does not** allow time to address **new or existing** health problems properly. These would qualify as separate services and require a longer appointment. Please let our scheduling staff know if you need the physician's help with a health problem or more pressing concerns, other than the wellness visit. We may need to schedule a separate appointment to complete the wellness at a later date. If performed, a separate charge applies to these services.

We hope that this helps clarify your Medicare wellness benefits.

SCREENING AND PREVENTATIVE SERVICES

Screening/Test	**Please write the most recent dates for the following screenings:**
Pneumococcal Vaccines (ex: Prevnar/ Pneumovax)	Date Completed: _____
Influenza Vaccine	Date Completed: _____
Shingles Vaccine	Date Completed: _____
COVID Vaccine	Date Completed: _____
RSV Vaccine	Date Completed: _____
TDAP Vaccine	Date Completed: _____
Lung Cancer Screening	Date Completed: _____ Results Normal? YES☐ NO☐ UNSURE☐
Mammogram Screening	Date Completed: _____ Results Normal? YES☐ NO☐ UNSURE☐
Bone Density Screening	Date Completed: _____ Results Normal? YES☐ NO☐ UNSURE☐
Colorectal Cancer Screening	Date Completed: _____ Results Normal? YES☐ NO☐ UNSURE☐
PAP Smear (females only)	Date Completed: _____ Results Normal? YES☐ NO☐ UNSURE☐
PSA Screening (males only)	Date Completed: _____ Results Normal? YES☐ NO☐ UNSURE☐
Eye Exam	Date Completed: _____ Results Normal? YES☐ NO☐ UNSURE☐

List of Providers:

Primary care Physician/Provider(s):

Clinic/Provider Name	Location

Specialist(s):

Clinic/Provider Name	Location	Specialty

Alternative Medicine Providers: (chiropractor, acupuncturist etc.)

Clinic/Provider Name	Location	Specialty

Preferred Pharmacy(s): Name/Location

Pharmacy Name	Location

Dentist:

Name	Location

PHQ-9 Questionnaire

Over the **last 2 weeks**, how often have you been bothered by the following problems?	Not at All	Several Days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
Feeling down, depressed or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
Feeling bad about yourself- or that you are a failure or that you have let yourself or family down	0 ☐	1 ☐	2 ☐	3 ☐
Trouble concentrating on things such as reading or watching television	0 ☐	1 ☐	2 ☐	3 ☐
Moving or speaking so slowly that other people 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 ☐
Thought that you would be better off dead, or Hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

_____Not difficult at all _____Somewhat difficult _____Very difficult _____Extremely difficult

Medicare Wellness: Health Risk Assessment

Living Situation

1) What is your living situation today?
   ___ I have a steady place to live
   ___ I have a place to live today, but I am worried about losing it in the future
   ___ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
2) Think about the place you live. Do you have problems with any of the following?
   CHOOSE ALL THAT APPLY
   ___ Pests such as bugs, ants or mice
   ___ Mold
   ___ Lead paint or pipes
   ___ Lack of heat
   ___ Oven or stove not working
   ___ Smoke detectors missing or not working
   ___ Water leaks
   ___ None of the above

Food

3) Within the past 12 months, are you worried that your food would run out before you got money to buy more?
   ___ Often true
   ___ Sometimes true
   ___ Never true
4) Within the past 12 months, the food you bought just did not last and you did not have money to get more.
   ___ Often true
   ___ Sometimes true
   ___ Never true

Transportation

5) In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things need for daily living?
   ___ Yes
   ___ No

Utilities

6) In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
   ___ Yes
   ___ No
   ___ Already shut off

Safety

Because violence and abuse happen to a lot of people and affects their health, we are asking the following questions:

7) How often does anyone, including family and friends, physically hurt you?
___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
8) How often does anyone, including family and friends, insult or talk down to you?
___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
9) How often does anyone, including family and friends, threaten you with harm?
___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
10) How often does anyone, including family and friends, scream or curse at you?
___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
11) In general, would you say your health is:

___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

12) How have things been going for you during the past 4 weeks?
___ Very well; could hardly be better
___ Good and bad parts about equal
___ Very bad; could hardly be worse
13) How confident are you that you can control and manage most of your health problems/issues?
___ Very Confident ___ Somewhat confident ___ Not very confident
___ I do not have any health problems
14) How often in the **last 4 weeks,** have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing					
Sexual problems or concerns					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Problems sleeping					
Tiredness or fatigue					

15) Have you fallen two or more times in the past year? ___ Yes ___ No

16) Are you afraid of falling? Do you feel unsteady? ___ Yes ___ No

17) HOME SAFETY CHECKLIST
- Are entrance ways well lit? ___ Yes ___ NO
- Are sidewalks/entrance ways maintained? ___ Yes ___ No
- Is a carbon monoxide detector installed? ___ Yes ___ No
- Are smoke detectors installed? ___ Yes ___ No
- Are all medicines kept in original containers with original labels intact? ___ Yes ___ No
- Do you throw out all unidentified or out of date medications? ___ Yes ___ No

18) How often do you have trouble taking medications the way you have been told to take them?
___ I do not have to take medicine
___ I always take them as directed
___ Sometimes I take them as directed
___ I seldom take them as directed

19) Do you have difficulty driving your car?
___ Yes, often ___ Sometimes ___ No ___ N/A – I do not use a car

20) Do you always fasten your seat belt when you are in a car?
___ Yes, always ___ Yes, sometimes ___ No

21) How often in the **last 4 weeks** have you experienced the following:

	Never	Seldom	Sometimes	Often	Always
Straining to understand conversation					
Trouble hearing in a noisy background					
Misunderstanding what others are saying					

22) During the **last 4 weeks,** how much have you been bothered by feelings of anxiety, depression, irritability or sadness?
___ Not at all ___ Slightly ___ Moderately ___ Extremely

23) During the **last 4 weeks,** has your physical or emotional health limited your social activities with family and friends?
___ Not at all ___ Slightly ___ Moderately ___ Extremely

24) During the **last 4 weeks,** how much bodily pains have you generally had?
___ Not at all ___ Slightly ___ Moderately ___ Extremely

25) Do you have someone who is available to help you if you needed or wanted help?
___ Yes, as much as I want/need ___ Yes, some ___ No, not at all

26) Because of any health problems, do you need the help of another person with your personal care needs, such as eating, bathing, dressing, or getting around the house?
____ Yes ____ No

27) Because of any health problems, do you need the help of another person with shopping, preparation of meals, or house work?
____ Yes ____ No

28) Can you handle your own money without help?
____ Yes ____ No

29) During the **last 4 weeks,** did you exercise for about 20 minutes, 3 or more days a week?

___ Yes, most of the time

___ Yes, some of the time

___ No, I usually do not exercise

___ No, I am not currently exercising

30) When you exercise, how intensely do you typically exercise?

___ Light (stretching/slow walking)

___ Moderate (brisk walking)

___ Heavy (jogging/swimming)

___Very heavy (running/stair climbing)

31) Are you a smoker/tobacco user?

___ No-never ___ No-former ___ Yes, and I am interested in quitting ___ Yes, I am not ready to quit

32) In the **last 7 days,** how many of those days did you drink alcohol? _____ days

33) On the days that you drank alcohol, how often did you have 4 or more drinks?

___ Never ____ Once during the week ____ 2-3 times during the week

___ More than 3 times during the week

CAGE ASSESSMENT

Question	YES	NO
Have you ever felt you should **C**ut down on your drinking?		
Have people **A**nnoyed you by criticizing your drinking?		
Have you ever felt bad or **G**uilty about your drinking?		
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?		
TOTAL		
Scoring: Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.		

YAY YOU ARE DONE!

Thank you for completing this Medicare Wellness Health Risk Assessment 😊