Age 65+ Wellness Visit

(includes Medicare Annual Wellness, Humana Annual Wellness, & other insurances)

We want you to receive wellness care – health care that may lower your risk of illness or injury. Medicare and other insurances pay for most wellness care but may not pay for all the wellness care you might need.

MEDICARE COVERS:

- A "WELCOME TO MEDICARE" visit one time within the first 12 months on Medicare
- An ANNUAL "Wellness Visit" every year
- <u>If you don't have Medicare</u> – most insurance plans cover Wellness visits, but you should verify this with your insurance.

COST TO ME:

- Medicare covers the entire cost (no deductible or co-pay) for the Annual Wellness exam. BUT, if a significant portion of the visit is for medical problem related discussion/evaluation, the doctor may bill a regular office visit charge in addition to the Wellness Visit.
- If testing is recommended, there may be cost (co-pay, deductible)

What is included:

- Height, weight, and BP measurements – calculation of BMI
- Review of your medical and family history
- Simple vision test for Welcome to Medicare visit
- Health risk assessment
- Offer to discuss 'end of life issues' if you wish
- **Written plan** letting you know what screenings, shots, and other preventive services you need

A wellness visit does not deal with new or existing health problems. That would be a separate service and requires a different appointment. Please let our scheduling staff know if you need the doctor's help with a health problem or something else – so that a separate visit can be scheduled. Medicare and most insurances do not cover both types of appointments on 1 day.

<u>WHAT YOU NEED TO DO – Checklist:</u>

- ☐ Complete the attached form as completely as possible
- ☐ A Snapshot of your health record is attached. Please review and indicate any missing or incorrect information
- ☐ Bring this form to your WELLNESS appointment – and give to the nurse when you are checked into the exam room
- ☐ BRING YOUR MEDICATION BOTTLES with you – we need to verify ALL medications that you are taking

Your WELLNESS visit is scheduled: ______________________________ @ _________ am/pm

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Name	Chart#	D.O.B.	Date

FAMILY HISTORY – please ✓to indicate positive history

	Father	Mother	Children	Siblings	GrandPar
Cancer					
Diabetes					
High blood pressure					
Heart disease					
Stroke					

PERSONAL HABITS & ACTIVITIES

Use Tobacco Products	☐ Yes, every day but I would like to quit ☐ Never have ☐ Yes, every day but I am not ready to quit ☐ Have in past – quit in _________
Alcohol Use	☐ Never ☐ Monthly or less ☐ 2-4 times/mo ☐ 2-3 times/wk ☐ 4 times/wk or more
# of drinks on typical day	☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7, 8, or 9 ☐ 10 or more
Drug Use	☐ Never ☐ IN past, quit ____ ☐ Monthly or less ☐ Weekly ☐ Daily
Diet	☐ Low fat/chol ☐ diabetic ☐ Eat whatever I want ☐ Other
Sexual History	☐ Not sexually active ☐ heterosexual ☐ homosexual ☐ bisexual
Physical Activity	Minutes of vigorous exercise/week _________ Min of less than vigorous/week __________
Work	☐ retired – in past ____ ☐ part-time ☐ full-time I work because: ☐ I have to financially ☐ I want to & enjoy it

HOSPITALIZATIONS	Have you been hospitalized (stayed overnight) in a hospital in the past year? ☐ yes ☐ no If yes – what hospital ________________________________ Dates ___________________ ________________________________ Dates ___________________
FRACTURES	Have you had any fracture (broken bone) in the last year? ☐ no ☐ yes

LIFESTYLE

Living arrangements	☐ Live Alone ☐ Live with Spouse ☐ Live with Children ☐ Live with Family Members ☐ Live with Significant Other
Type of Residence	☐ House ☐ condo/apartment ☐ Sr living ☐ assisted living ☐ Nursing home
How many stories/floors	☐ Single story (1 floor) ☐ Two Story (2 floors) ☐ Three Story (3 floors)
Do you use any of the following	Nebulizer: ☐ yes ☐ no Oxygen: ☐ yes ☐ no [LPM _______] CPAP/Bipap: ☐ yes ☐ no
Transportation you use	☐ I drive my own car ☐ passenger in my own car ☐ family drive me ☐ I rely on public transportation (bus/cab/RCAT)

SELF-ASSESSMENT OF HEALTH

How would you rate your health compared to others your age? ☐ Better ☐ Worse ☐ Same
How would you rate your health today compared to last year? ☐ Better ☐ Worse ☐ Same
Do you have pain? ☐ none or very little ☐ Yes, on a scale of 0-10, it is _________ Location

How much, if any, is bladder control for you? ☐ Small problem ☐ Big problem ☐ Not a problem

How often does your physical health interfere with daily activities? ☐ Almost never ☐ Occasionally ☐ Frequently

How would you describe your emotional health? ☐ Calm/peaceful ☐ Energetic ☐ Downhearted or blue

MEDICATIONS

Remembering to take medications can sometimes be a challenge. In the last 2 weeks, have you forgotten to take your medications? Yes No

Understanding how and when to take medications and knowing why it was prescribed is important. Do you have any questions on how or when to take you medications, or why it was prescribed? Yes No

Some medications are difficult to afford, even with help from copayments. Do you have any medications that are not affordable? Yes No

Every medication can have side effects. D you have any unanswered worries or questions related to your medication's side effects? Yes No

DEPRESSION SCREENING

Over the last 2 weeks, how often:	Not at all	Several Days	More than 7	Nearly Every Day
Have you had little interest/pleasure in doing things?	☐	☐	☐	☐
Have you felt down, depressed, or hopeless?	☐	☐	☐	☐

FUNCTIONAL STATUS

Do you or people around you have concerns about your hearing? ☐ Yes ☐ No ☐ I wear hearing aides

Do you or people around you have concerns about your vision? ☐ Yes ☐ No ☐ I wear glasses/contacts

Do you use any of the following for assistance? Cane: ☐ yes ☐ no Walker: ☐ yes ☐ no
Crutches: ☐ yes ☐ no Wheelchair/Scooter: ☐ yes ☐ no

FALL SCREENING

In the past year - have you had any falls? ☐ yes ☐ no If yes, now many? ____ Injury from fall? ☐ yes ☐ no

In the past year - have you had concerns about balance or walking or feeling unsteady on your feet? ☐ yes ☐ no

Does your home have any trip hazards like throw rugs or uneven floors? ☐ yes ☐ no

Does your bathroom LACK grab bars in the tub and around the toilet, or handrails on the stairs/steps? ☐ yes ☐ no

ACTIVITIES OF DAILY LIVING – for each activity, please check the appropriate column

	I can do by myself	Need some assistance	Need total assistance	Who helps you with this?
Bathing	☐	☐	☐	
Dressing	☐	☐	☐	
Grooming	☐	☐	☐	
Toileting	☐	☐	☐	
Transferring – bed to chair	☐	☐	☐	
Walking	☐	☐	☐	
Climbing Stairs	☐	☐	☐	
Eating	☐	☐	☐	
Shopping	☐	☐	☐	
Cooking/Meal Preparation	☐	☐	☐	
Managing Medications	☐	☐	☐	
Using Phone	☐	☐	☐	
Housework	☐	☐	☐	
Laundry	☐	☐	☐	
Driving – Using Public Trans	☐	☐	☐	
Financial Management	☐	☐	☐	
Home Repairs	☐	☐	☐	

ADVANCED CARE PLANNING

Do you have a LIVING WILL? ☐ yes ☐ no

Have you signed a Do Not Resuscitate directive? ☐ yes ☐ no

Do you have a DURABLE POWER of ATTORNEY for HEALTHCARE? ☐ yes ☐ no

Do you wish to talk to your physician about END-OF-LIFE wishes for medical care? ☐ yes ☐ no

RISK FACTORS – to help use determine what other tests/evaluations may be needed, please answer the following

Aortic Aneurysm	Do you have a brother/sister/mother/father with abdom aortic aneurysm?	☐ yes	☐ no
	Are you male, age 65-75, and smoked @ least 100 cigarettes in your lifetime?	☐ yes	☐ no
Bone Mass	Have you ever been diagnosed with osteoporosis?	☐ yes	☐ no
	Do you take Calcium (1200 mg or more) and Vit D (800 IU or more) daily?	☐ yes	☐ no
	Have you had a bone density (DEXA) scan? ☐ never ☐ yes – date of last?		

Cervical Cancer	Have you had a PAP test in the last seven years?	☐ no ☐ yes
	Have you had less than 3 NEGATIVE pap tests in your life?	☐ yes ☐ no
	Was your first intercourse at age 16 or less?	☐ yes ☐ no
	Have you had 5 or more sexual partners in your lifetime?	☐ yes ☐ no
	Do you have a history of sexually transmitted disease (STD)?	☐ yes ☐ no
Colorectal Cancer	Do you have a sibling/parent/child with colon cancer or polyps?	☐ yes ☐ no
	Do you have a family history of "familial adenomatosis polyposis?	☐ yes ☐ no
	Do you have a family history of "hereditary colorectal cancer"?	☐ yes ☐ no
	Have you ever had colon cancer, ulcerative colitis, or Crohn's disease?	☐ yes ☐ no
Diabetes	Have you ever been diagnosed with high blood pressure?	☐ yes ☐ no
	Do you have a history of high cholesterol?	☐ yes ☐ no
	Is your BMI (body mass index) over 30?	☐ yes ☐ no
	Do you have a personal history of a previously elevated blood sugar?	☐ yes ☐ no
Glaucoma	Ever been diagnosed with diabetes?	☐ yes ☐ no
	Family history of diabetes?	☐ yes ☐ no
	African-American and age OVER 50?	☐ yes ☐ no
	Hispanic-American and age OVER 65?	☐ yes ☐ no
Hepatitis B	Do any of the following apply to you? - on dialysis or have end-stage renal disease? - have hemophilia – or received Factor VIII or IX concentrate - live in the same household as someone with hepatitis B - are you a homosexual male - have you used illegal/illicit INJECTABLE drugs ever?	☐ yes ☐ no
HIV	Do any of the following apply to you? - Men who have had sex with men after 1975; - men and women having unprotected sex with multiple partners; - past or present injection drug users; - men and women who exchange sex for money or drugs or have sex partners who do; - individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users; - persons being treated for sexually transmitted diseases (STDs); - persons with a history of blood transfusion between 1978 and 1985.	☐ yes ☐ no

OTHER HEALTHCARE PROVIDERS – please list names (all doctors you see) and reasons you see

Specialty	*Name*	*City*	*Reason you see*
Eye Doctor			
Dentist			

What PHARMACY do you use?

Is there anything about your health that we didn't cover that we should know?

SNAPSHOT of your medical record – please review. Is all the information contained correct? ☐ yes ☐ no

Name of person completing this form:

Name ____ DOB _____________ MRN ________________

We are required to document all known medical conditions in your medical record.

Please help us by reviewing each question and answer Y)es or N)o if you don't know, put ? mark. You may not have heard of many of the terms – and answer no for these. If you have had one of these, you would most likely have heard or be familiar with the term. If you have questions, please ask your provider.

		Have you EVER had, or been told you have (if choices, circle)
Y	N	Hospitalized with SEVERE infection of any kind *(sepsis, SIRS)*
Y	N	TB or tuberculosis, cytomegalovirus, toxoplasmosis, aspergillus, Cryptococcus, Mucormycosis
Y	N	Cancer of any type (other than skin cancer), or leukemia or lymphoma
Y	N	Eye problem from your eye doctor – macular degeneration, diabetic retinopathy, etc
Y	N	Disorder or problem with thyroid, parathyroid, pituitary, adrenal glands, thymus
Y	N	Cirrhosis of liver, chronic hepatitis, end-stage liver disease
Y	N	Perforation or rupture of stomach/intestine/diverticuli, peritonitis, infection of abdominal cavity
Y	N	Pancreatitis that has been diagnosed as chronic
Y	N	Crohn's disease or ulcerative colitis
Y	N	An infection of bone, muscle, a joint, or muscle eating type infection
Y	N	Rheumatoid arthritis, ankylosing spondylitis, pericarditis, dermatomyositis, polymyositis
Y	N	Severe problem with blood clotting
Y	N	Drug or alcohol dependence or addiction
Y	N	Schizophrenia
Y	N	Depression, bipolar disorder, other psychiatric disorder
Y	N	Paralysis – quadriplegia, paraplegia
Y	N	Myasthenia Gravis, Guillan-Barre syndrome
Y	N	Multiple sclerosis
Y	N	Seizures, epilepsy, convulsions
Y	N	Coma, traumatic brain injury, brain damage from lack of oxygen
Y	N	Respiratory arrest i.e. quit breathing requiring resuscitation or use of breathing machine or ventilator
Y	N	Cardiac arrest requiring CPR, resuscitation, breathing machine
Y	N	Congestive heart failure
Y	N	Heart attack, myocardial infarction
Y	N	Ongoing chest pain from heart, angina, occurs with exertion or physical activity
Y	N	Atrial fibrillation, atrial flutter, heart block, ventricular fibrillation, v-fib or other heart rhythm problem
Y	N	Stroke or bleeding into brain
Y	N	Weakness or paralysis on one side or more from stroke
Y	N	Blood vessel blockages in arm or leg, ulcer of extremity, gangrene
Y	N	Pulmonary embolus, blood clot in extremity or lung, dissection of vessel, aneurysm, blockage of artery to extremity or organ
Y	N	COPD, emphysema, chronic lung disease, asthma, fibrosis
Y	N	Pneumonia, lung abscess
Y	N	Skin ulceration, deep sore
Y	N	Severe head injury
Y	N	Spine fracture
Y	N	Hip fracture or dislocation
Y	N	Complication of implanted joint, pacemaker, graft, or any device or material inserted into your body
Y	N	Transplant of bone marrow, stem cell, kidney, liver, lung or any other organ or body part
Y	N	Ostomy of any type – bowel, bladder, stomach, etc

THANK YOU for your help with this.