Dear Patient:

We want you to receive wellness care-health care that may lower your risk of illness or injury. Medicare pays for most wellness care, but it does not pay for all the wellness care you might need. We want to know about your Medicare benefits and how we can help you get the most from your insurance.

The term "physical" is often used to describe wellness care. But Medicare does not pay for a traditional, head-to-toe physical. Medicare does pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:

- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- Recommendations for other wellness services and healthy lifestyle changes,
- Discuss Medicare-covered services that allow our care team to more closely monitor your health conditions and update your plan of care before office visits.

Before your appointment, our staff will ask you some questions about your health and may ask you to fill out a form to help identify your health risks.

A wellness visit does not deal with new or existing health problems. That would be a separate service and requires a longer appointment. Please let our scheduling staff know if you need the doctor's help with a health problem, a medication refill or something else. We may need to schedule a separate appointment to address problems. A separate charge applies to these services, whether provided on the same date or a different date than the wellness visit.

We hope to help you get the most from your Medicare Wellness benefits. Please contact us with any questions.

***Please bring this document back to us 1 week before your next appointment.**

Name: _____ **Date of Birth:** _____

Date: _____

Medicare Wellness Checkup:

1. During the past 4 weeks, how much of you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue.

   ☐ Not at all
   ☐ Slightly
   ☐ Moderately
   ☐ Quite a bit
   ☐ Extremely

2. During the past 4 weeks has her physical and emotional health limited your social activities with family, friends, neighbors, or groups?

   ☐ Not at all
   ☐ Slightly
   ☐ Moderately
   ☐ Quite a bit
   ☐ Extremely

3. During the past 4 weeks how much bodily pain have you generally had?

   ☐No pain
   ☐Very mild pain
   ☐Mild pain
   ☐Moderate pain
   ☐Severe pain

4. During the past 4 weeks is there someone available to help you, if you need it, and wanted help? (For example, if you felt very nervous, lonely, or blue; get sick and had to stay in bed; needed someone to talk to, help with daily chores.)

   ☐Yes, as much as I wanted
   ☐Yes, quite a bit
   ☐Yes, some
   ☐Yes, a little
   ☐No, not at all

5. During the past 4 weeks what was the hardest physical activity he would do for at least 2 minutes?

   ☐ Very heavy
   ☐ Heavy
   ☐ Moderate
   ☐ Light
   ☐ Very light

6. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)
   ☐ Yes ☐ No

7. Can you go shopping for groceries or clothes without someone's help?
   ☐ Yes ☐ No

8. Can you prepare your own meals?
   ☐ Yes ☐ No

9. Can you do your housework without help?
   ☐ Yes ☐ No

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

11. Can you handle your own money without help?
    ☐ Yes ☐ No

12. During the past 4 weeks how would you rate your health in general?
    ☐ Excellent
    ☐ Very good
    ☐ Good
    ☐ Fair
    ☐ Poor

Name: _____ **Date of Birth:** _____

Date: _____

13. How's things been going for you during the past 4 weeks?

☐Very well: could hardly be better
☐Pretty well
☐Good and bad parts about equal
☐Pretty bad
☐Very bad: could hardly be worse

14. Are you having difficulties driving your car?

☐Yes, often
☐Sometimes
☐No
☐Not applicable, I do not use a car

15. Do you always fasten your seat belt when you are in a car?

☐Yes, usually
☐Yes, sometimes
☐No

16. How often during the past 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up					
Sexual Problems					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Tired or Fatigue					

17. Have you fallen two or more times in the past year?

☐ Yes ☐ No

Name: _____ **Date of Birth:** _____

Date: _____

18. Are you afraid of falling?

☐ Yes ☐ No

19. During the past four weeks how many drinks of wine, beer or other alcoholic beverages did you have?

☐10 or more drinks per week
☐6-9 drinks per week
☐2-5 drinks per week
☐One drink or less per week
☐No alcohol at all

20. Do you exercise for about 20 minutes three or more days a week?

☐Yes, most of the time
☐Yes, some of the time
☐No, I usually do not exercise this much

21. Have you been given any information to help you with the following:

Hazard in your house that might hurt.

☐ Yes ☐ No

Keeping track of your medications?

☐ Yes ☐ No

22. How often do you have trouble taking medicines the way you have been told to take them?

☐I do not have to take medicine
☐I always take them as prescribed
☐Sometimes I take them as prescribed
☐I seldom take them as prescribed

23. How confident are you that you can control and manage most of your health problems?

☐Very Confident
☐Somewhat confident
☐Not very confident
☐I do not have any health problems.

Name: _____ **Date of Birth:** _____

Date: _____

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, Depressed or hopeless				
3. Trouble falling or staying asleep, or sleeping 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				

If you are experiencing any of the problems in this form, 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

Name: _____ **Date of Birth:** _____

Date: _____

LIST OF MEDICINES					
Name of Medication	**Color**	**What it's for?**	**Dosage**	**Time**	**Special instructions**