Dear Patient,

Medicare will now pay for an **Annual Wellness Visit** and certain screening tests without deductibles or copays. As your health care provider, we encourage you to have one every year and want you to be aware of the specific Medicare guidelines for the wellness visit. An Annual Wellness Visit is not a comprehensive physical exam.

The Annual Wellness Visit will include:

- Updating your medical and social history, including a list of all your health care providers
- Assessing health risk factors and the presence of any medical conditions
- Blood pressure, height, weight and BMI measurements.
- Screening for conditions related to cognitive impairments, depression and functional status.

At this visit your provider will work with you to create a personalized plan to help keep you healthy over the next few years. Subsequent Annual Wellness Visits will update the information gathered at the first visit.

The Annual Wellness Visit is not a physical exam but rather a review of your health, plus education and counseling about preventive services. To provide our patients with the most comprehensive medical care, if you have other chronic or acute medical conditions we may perform a physical exam and/or cover medical issues at the time of your appointment which is not considered part of the Annual Wellness Visit by Medicare. If this is done, a separate office visit charge will be billed where deductibles and copays would apply.

Preparation for your visit

Arrive 15 minutes early to complete a Medicare Wellness Visit Questionnaire.

Bring:

-All prescription and over-the-counter medications, inhalers, vitamins or supplements in their bottles.

-Name, address and phone number of any specialist(s) you may have seen since your last visit with us.

-A copy of your Advance Directive or Durable Power of Attorney for Healthcare if you have not already provided us with one.

Sincerely,

Your Infinity Primary Care Provider

MEDICARE WELLNESS QUESTIONNAIRE

Patient Name: ______________________________

Patient DOB: ______________________________

Today's Date: ______________________________

ADVANCE DIRECTIVES

1. Do you have a durable power of attorney for healthcare?
   YES NO
2. Do you have a living will?
   YES NO
3. Would you like more information about a living will and durable power of attorney?
   YES NO

PAIN

On a scale of 1-10 are you having pain today?
(1 being the lowest and 10 being the highest)
YES NO

1. If yes, where is the pain located?
2. When did your pain start?
3. Please circle one- which best describes your type of pain?

Aching	Sharp
Burning	Shooting
Discomforting	Stabbing
Dull	Throbbing
Gnawing	Tingling
Piercing	

FALL RISK

1. Have you fallen in the last year?
   YES NO
2. If yes, how many times have you fallen?
3. Did the fall(s) result in an injury?
   YES NO
4. If yes, please describe:
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____

QUALITY OF LIFE

Over the last 2 weeks how often have you been bothered by any of the following problems? (circle one)

1. Little interest or pleasure in doing things
   Not at all — Several days
   More than half the days — Nearly every day
2. Feeling down, depressed or hopeless
   Not at all — Several days
   More than half the days — Nearly every day

FUNCTIONAL ABILITY, SAFETY, HOME ENVIRONMENT

1. Are you able to climb stairs? (circle one)
   ABLE TO — NOT ABLE TO — FIND IT DIFFICULT
2. Are you able to exercise? (circle one)
   ABLE TO — NOT ABLE TO — FIND IT DIFFICULT
3. Are you able to get in and out of the cars?
   ABLE TO — NOT ABLE TO — FIND IT DIFFICULT
4. Are you able to go downstairs?
   ABLE TO — NOT ABLE TO — FIND IT DIFFICULT
5. Are you able to go upstairs?
   ABLE TO — NOT ABLE TO — FIND IT DIFFICULT
6. Are you able to kneel?
   ABLE TO — NOT ABLE TO — FIND IT DIFFICULT
7. Are you able to perform activities of daily living?
   ABLE TO — NOT ABLE TO — FIND IT DIFFICULT
8. Are you able to put on socks and shoes?
   ABLE TO — NOT ABLE TO — FIND IT DIFFICULT
9. Are you able to walk?
   ABLE TO — NOT ABLE TO — FIND IT DIFFICULT
10. Are you able to walk 10 blocks?
    ABLE TO — NOT ABLE TO — FIND IT DIFFICULT
11. Are you able to walk an unlimited distance?
    ABLE TO — NOT ABLE TO — FIND IT DIFFICULT
12. Are you able to walk 5 to 10 blocks?
    ABLE TO — NOT ABLE TO — FIND IT DIFFICULT

MEDICARE WELLNESS QUESTIONNAIRE

Patient Name: ____________________________________
Patient DOB: _____________________________________
Today's Date: ____________________________________

FUNCTIONAL ABILITY, SAFETY, HOME ENVIRONMENT, CONT'D

13. Do you need help with activities of daily living?
    YES NO

14. Do you have smoke detectors in your home?
    YES NO

15. Do you have firearms in your home?
    YES NO
    If yes, please answer the questions below.
    - How many do you have in your home?
      ____
    - Are your firearms locked?
      YES NO
    - Do you use a trigger guard on the firearms?
      YES NO
    - Do you store your ammunition separately from the firearm(s)?
      YES NO
    - Are your firearms unloaded for storage?
      YES NO
    - Your firearms are kept for: (Please circle all that apply)
      Recreation Occupation
      Hunting Protection

16. Do you use a seatbelt in a vehicle?
    YES NO

17. Do you have carbon monoxide detectors in your home?
    YES NO

18. Is there Radon in your home? (Circle one)
    Treated Untreated

19. What type of home heating do you have? (Circle one)
    Coal Oil
    Electric Solar
    Gas Wood

NUTRITION

1. What type of diet do you follow? (Circle one)
   1600 Calorie 1800 Calorie
   2000 Calorie Diabetic
   Gluten Free Healthy
   High Calorie High Fat
   High Roughage High Salt
   Junk Food Low Fat
   Low Residue Low Salt
   No Red Meat Vegan
   Vegetarian

2. Do you use a Calcium supplement?
   YES NO
   If yes, how many mg. per day? ___________________

3. Do you take a daily multivitamin?
   YES NO

4. Do you take a Vitamin D supplement?
   YES NO

5. Do you take Folic Acid?
   YES NO

TOBACCO AND ALCOHOL

1. Do you use Tobacco? (circle one)
   YES NO FORMER

2. Do you have passive smoke exposure? (circle one)
   YES NO FORMER

3. Do you drink alcohol?
   YES NO
   If yes, please answer the questions below.
   - If yes, what type(s) circle all that apply:
     Beer Rum
     Beer and Liquor Scotch
     Beer and Wine Vodka
     Gin Whiskey
     Hard Liquor Wine
   - How frequently do you drink alcohol? (circle one)
     Daily Occasionally
     Weekly Rarely
     Monthly Socially
     Yearly
   - How much alcohol do you think you drink at one time? (circle one)
     1 Drink 6 Drinks
     2 Drinks 7 or more Drinks
     3 Drinks 1 Fifth
     4 Drinks 1 Pint
     5 Drinks
   - When was your last drink? (circle one)
     Today Last Night
     Yesterday Last Month
     Last Week Two weeks ago
     One Year Ago

MEDICARE WELLNESS QUESTIONNAIRE

Patient Name: ___________________________________
Patient DOB: ____________________________________
Today's Date: ___________________________________

Please list all specialty Physicians that you have seen in the last year:

Eye Care Specialist: ________________________________
Phone Number: ____________________________________

Provider Name: ____________________________________
Specialty: ____
Phone Number: _____________________________________
Reason/Diagnosis: __________________________________
Last Visit: ____

Provider Name: ____________________________________
Specialty: ____
Phone Number: _____________________________________
Reason/Diagnosis: __________________________________
Last Visit: ____

Provider Name: ____________________________________
Specialty: ____
Phone Number: _____________________________________
Reason/Diagnosis: __________________________________
Last Visit: ____

Provider Name: ____________________________________
Specialty: ____
Phone Number: _____________________________________
Reason/Diagnosis: __________________________________
Last Visit: ____

Provider Name: ____________________________________
Specialty: ____
Phone Number: _____________________________________
Reason/Diagnosis: __________________________________
Last Visit: ____