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Medicare Wellness

- **This visit is based off of this paperwork.**

- **If you do not have your paperwork COMPLETED by your appointment time, your appointment will be RESCHEDULED.**

- **During this appointment we cannot address any chronic/acute issues or refill any medications due to medicare regulations.**

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1041 Balch Road, Suite 300, Madison, AL 35758 | IntegrityFamilyCare.com | P:256.325.1540 F:256.774.9040

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Annual Medicare Wellness Questionnaire

Today's Date: _____

Patient Name: _____ **DOB**: _____

Please complete this questionnaire before seeing your provider. The answers to your questions will help us provide you with the care you deserve to support your wellbeing and quality of life.

Please circle Yes or No:

Have you ever had a Medicare Wellness Exam?	**YES**	or	**NO**
If yes, has it been 12 months since your last one?	**YES**	or	**NO**
Have you been contacted by your Chronic Care Manager?	**YES**	or	**NO**
Have you had your Hepatitis C screening (born 1945-1965)?	**YES**	or	**NO**
Have you had your Shingles vaccine?	**YES**	or	**NO**

Please enter date:

When was your last FLU shot? Date_____

When was your last PNEUMONIA shot? Date_____

When was your last Colonoscopy? Date_____

If you are Diabetic, please enter date:

When was your last foot exam? Date_____

When was your last eye exam? Date_____

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Women, please enter date:

When was your last mammogram? Date_____

When was your last bone density scan? Date_____

Please circle what best describes you:

Diet & Nutrition:

- Healthy Diet
- High Caloric Intake
- Diet high in salt
- Nonsmoker
- Alcohol use per week:
  NONE 1-3 drinks 4-6 drinks 7 or more drinks
- Diet is high in fat, low in fiber
- High carb meals
- Low calcium intake
- Former smoker, ___ years since quit
- Current every day smoker, ___ PPD

Circle yes or no:

Have you had your one-time screening for smoker history? **YES** or **NO**

*AAA (male age 65-75)
*Low Dose CT scan (age 55-77, no symptoms, current smoker OR quite <15yrs ago, >30 pack years total)

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Fracture Risk:

- No history of fractures
- No sudden unexplained fractures

- History of Fractures
- Sudden unexplained fracture

Physical Activity:

- Exercises regularly
- Good physical condition

- Does not exercise regularly
- Poor physical condition

Depression Risk:

- I never feel sad or tearful
- No loss of interest
- No history of depression

- I feel sad and/or tearful at this time
- I have a loss of interest in activities
- History of depression

Orientation:

- No disorientation

- Disorientation to: time, date, place

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Concentration & Memory:

- No decreased concentration
- No memory lapses or loss
- Decreased concentration
- Memory lapses or loss

Speech/Motor difficulties:

- No speech difficulties
- No difficulty with fine motor tasks
- Speech difficulties
- Difficulty with fine motor tasks

Functional Ability:

- No loss of hearing
- Wears hearing aids
- No vision problems
- Loss of hearing: one / both ears
- Total vision loss

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Activities of Daily Living:

- Able to bathe / dress self
- Able to control bowel / bladder
- Able to manage medications
- Able to prepare own meals
- Unable to bathe / dress without help
- Loss or bowel / bladder control
- Unable to manage medications
- Unable to prepare own meals

Fall Risk Assessment:

- No fall in the past year
- No dizziness / vertigo
- Fall(s) in the past year: _____
- Dizziness / Vertigo
- Fear of falling

Home/self-safety:

- No unsafe floor hazards (rugs, clutter)
- Good lighting in home
- Working smoke detectors
- No driving problems
- Wears seatbelt
- Unsafe floor hazards (rugs, clutter)
- Poor lighting in home
- No smoke detectors
- Concerns regarding driving
- Does not wear seatbelt
- I have been to the hospital in the last 6 months

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Medical Legal Documents:

Medical Power of Attorney: someone to make medical decisions for you in the event you are unable to.

Living Will / Advance Directive: documents that make your healthcare wishes known

- I have a Medical Power of Attorney
- I have a Living Will / Advance Directive
- I do NOT have a Medical Power of Attorney
- I do NOT have a Living Will / Advance Directive

Pain Assessment:

None Mild (0-4) Moderate (4-5) Severe >5

Location of pain: _____

Controlled with medication: **YES** or **NO**

Please specify: _____

Do you have any new specialists that we need to add to your care team?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

CLOCK DRAW TEST:

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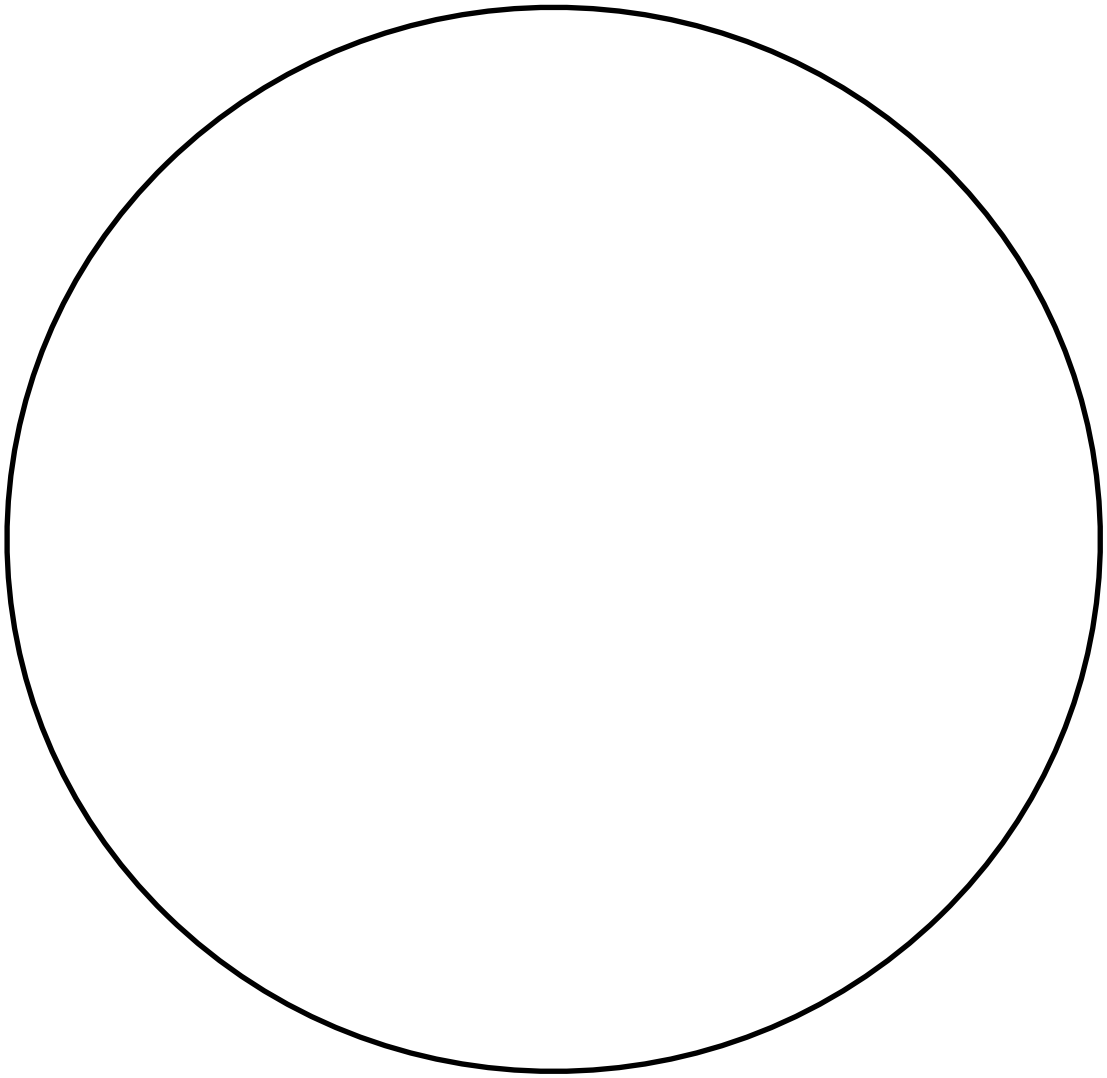
1. Inside the circle, please draw the hours of a clock as they normally appear.

2. Place the hands of the clock to represent the time: “ten minutes after eleven o’clock”



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STEADI Fall Risk	YES	NO
Have you fallen in the past year?		
Do you use or have you been advised to use a cane or walker to get around safely?		
Do you sometimes feel unsteady while walking?		
Do you steady yourself by holding onto furniture when walking at home?		
Do you worry about falling?		
Do you need to push with your hands to stand up from a chair?		
Do you have trouble stepping up onto a curb?		
Do you often have to rush to the toilet?		
Have you lost some feeling in your feet?		
Do you take medicine that sometime makes you light-headed or more tired than usual?		
Do you take medicine to help you sleep or improve your mood?		
Do you often feel sad or depressed?		

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PHQ 9

In the **past two weeks**, how often do you have these symptoms?

QUESTION:	Not at all	Several Days	More than Half the days	Nearly Every- Day
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 over eating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
Thoughts that you would be better off dead, or of 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 thing at home, or get along with people?	0	1	2	3

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