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MEDICAL GROUP

Medicare Wellness Visit

Patient's Name: _____ Date of Birth:_____

You are scheduled for a yearly preventative Medicare Wellness Visit:

on _____ at _____

We will go over your individual healthcare needs and make sure you are up to date and healthy!

Please completely fill out the following packet and bring it to your next appointment.

Please list all medications and supplements below; include the dosage and how many times a day you take it.

	Name of Medication	Dosage	When Taken
Sample	*Crestor*	*5ml*	*Each Morning*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

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Medicare Annual Visit Questionnaire

PATIENT'S INFORMATION	
NAME (Last, First, Middle)	BIRTHDATE

Tobacco/Alcohol	Circle the Answer
1. Do you use tobacco?	Yes No
2. Are you around other smokers?	Yes No
3. Do you use alcohol?	Yes No

Depression Screening	Circle the Answer
1. Recently have you felt down, depressed or hopeless?	Yes No
2. Recently have you felt little interest or pleasure in doing things?	Yes No

If you have answered Yes to any of the two previous questions, please continue to the next set of Depression questions. If you have answered No, then move to the next section.

Over the last two 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
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 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 in some way	0	1	2	3
ADD COLUMNS:				
	PHQ9 total score:			
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

Have you had surgery or been hospitalized since your last annual visit?	Yes	No
Do you have a hearing impairment?	Yes	No

Do you use any of the following?:

Hearing Aids Dentures Prosthesis Other: _____

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Function/Ability/Safety/Home Environment	Circle the Answer
1. Do you need help with activites of daily living? (Circle below)	
housekeeping shopping dressing	food preparation
2. Are you at a risk for falls?	Yes No
3. How many falls have you had in the last year?	# ____
4. Did the fall(s) result in injury?	Yes No
5. Do you have smoke detectors in your home?	Yes No
6. Do you have firearms in your home?	Yes No
7. Do you use a seat belt when in a vehicle?	Yes No
8. Do you have carbon monoxide detectors in your home?	Yes No
9. Has radon been detected in your home? Was it treated or left untested?	Yes No

Nutrition			
Do you take any of the following vitamins?			
Calcium	Yes	No	Amount
Multivitamin	Yes	No	Amount
Vitamin D	Yes	No	Amount
Folic Acid	Yes	No	Amount
Have you experienced weight loss?	Yes	No	Amount
Have you experienced weight gain?	Yes	No	Amount
What kind of diet do you maintain? For example - Low Fat, High Fat, 2000 Calorie			

Other Physicians	
Please list the names of your other Physicians:	Specialty

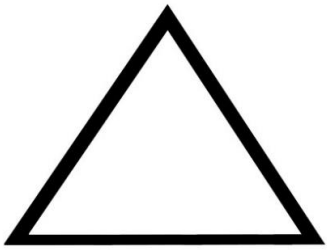
Medical Equipment & Supplies			
Do you use any of the following? (circle the answer):	Cane	Walker	Wheelchair
Medical Equipment Supplier (Oxygen or CPAP supplies?):			

Medicare Annual Visit Questionnaire

Cognitive Assessment

You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.

	Answer
1. How much did you spend?	
2. How much do you have left?	



Please place an x in the triangle.

Which is bigger, the triangle or the x?

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CLOCK DRAWING TASK

INSTRUCTIONS:

In the space below, please draw the face of a clock and put the numbers in the correct positions.

Now, draw in the hands at ten minutes after eleven.

Name _____

Date _____