Name: _____ **DOB:** _____

Account #: _____ **Today's Date** _____

Collins Medical Associates
Extraordinary Doctors ... Caring People

Medicare Annual Wellness Visit

We are pleased to inform you that Medicare is now covering some wellness services that were previously not reimbursed through a new visit entitled "Annual Wellness Visit."

Your Annual Wellness Visit with your provider is scheduled for:

_____

This is a series of screenings that allows your provider to identify conditions that might cause you to have future health problems before they become apparent to you, such as: falls, memory problems, depression and home safety.

We will also review any other Medicare preventative services for which you might be eligible such as vaccinations, and other screening exams. We may also discuss plans for a Living Will.

The Annual Wellness Visit is entirely paid for by Medicare and there is no cost to you. If you receive care for an existing or new problem during this visit, you may be charged for that part of the visit. The charges will vary depending upon your insurance company.

We look forward to seeing you soon.

PLEASE FILL OUT THE FOLLOWING PAGES PRIOR TO YOUR APPOINTMENT. BRING WITH YOU TO THE APPOINTMENT

Name: _____ **DOB:** _____

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Care Team – Enter any other providers you are currently receiving care from

Provider Name	Provider Specialty	Provider Office Phone

Mental Health - Check one answer for each question.

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy:				
Poor appetite or overeating:				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off any problems, how difficult have these problems made it for you to do your work or get along with other people? ☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult				

FALL RISK – Circle Yes or No for each question.

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

Name: _____ **DOB:** _____

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Social & Behavioral History

Diet – How would you best describe your diet? Check all that apply**.**

☐ Healthy diet ☐ High salt diet ☐ High calories
☐ High in fat, low in fiber ☐ High carbohydrates ☐ Low calcium intake
☐ Inadequate caloric intake ☐ I take vitamins or supplements

Dental Issues - Check all that apply**.**

☐ No dental changes ☐ I wear dentures ☐ I've had dental changes

Medications – Check all that apply**.**

☐ I have medicine at home, and I do not worry about affording my medications.
☐ I take my medication as prescribed and directed.
☐ I do not have medications at home and/or I have difficulty affording my medications.
☐ I am currently on an opioid medication.

Fracture Risk - Check all that apply**.**

I've broken a bone	☐ Recently	☐ In the past	☐ Never
I can explain how the bone broke	☐ Yes	☐ No	
I've previously had a muscular/skeletal injury	☐ Yes	☐ No	
I've had a bone scan (Bone Density Test)	☐ Yes, Date _____	☐No	

Physical Activity – Check all that apply

I exercise on a regular basis	☐ Yes	☐ No
I consider myself to be in good physical condition	☐ Yes	☐ No
I live an active lifestyle	☐ Yes	☐ No

Sexual Activity – Check all that apply**.**

☐ I do not have any difficulty ☐ I have difficulty with sexual activity or cannot perform

Pain – On a scale of 1-10 my pain is currently at: _____

Behavioral History – Check all that apply**.**

☐ In the past 12 months I've used prescription medications more than prescribed or that weren't prescribed to myself

☐ In the past 12 months I've used drugs (marijuana, cocaine, crack, heroine, PCP, hallucinogens, ecstasy/MDMA, etc.)

☐ In the past 12 months I've used tobacco products (cigarettes, vaping, chewing tobacco)

☐ In the past 12 months I've had 4 or more drinks containing alcohol in one day

☐ None of the above

Name: _____ **DOB:** _____

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Hearing & Vision – Check all that apply**.**

HEARING

☐ No hearing problems

☐ I wear hearing aids

☐ Loss of hearing ☐Both ears ☐One Ear

☐ I am having problems with my hearing. Please describe below:

VISION

☐ No vision problems

☐ Total vision loss

☐ I wear eyeglasses/contacts

☐ I am having problems with my vision. Please describe below:

Activities of Daily Living - Are you able to do the following with limited or no assistance? Circle yes or no for each activity.

Take a bath/shower	Yes	No	Do housework	Yes	No
Control my urination and bowels	Yes	No	Go grocery shopping	Yes	No
Get dressed	Yes	No	Manage my medications	Yes	No
Groom myself	Yes	No	Manage my finances/money	Yes	No
Feed myself	Yes	No	Prepare my own meals	Yes	No
Get out of a chair or bed	Yes	No	Use the phone	Yes	No
Get to and use the toilet	Yes	No	Use public transportation/drive	Yes	No

Home/Personal Safety – Circle yes or no for each item.

I have flooring hazards in my home (unsecured rugs, wires, lots of furniture in my way)	Yes	No
The stairs in my home have carpets torn, items on them, loose or no hand railings, no lighting in stairwell	Yes	No
I have gas appliances that may be defective or do not work or heat properly	Yes	No
I have working smoke detectors and carbon dioxide detectors in my home	Yes	No
I always wear my seatbelt when I am in the car	Yes	No
I have experienced vision or hearing loss when I've been driving	Yes	No
I have been in a motor vehicle accident – How many if yes? _____	Yes	No
I wear sun protection when I'm outside	Yes	No
I have firearms in my home	Yes	No
I have hand bars in my bathroom/shower	Yes	No
I have good lighting in my home	Yes	No
I practice "safer sex" – if applicable	Yes	No
I wear a helmet when biking - if applicable	Yes	No