AIKEN Physicians Alliance

NAME: _____

DOB: _____

TODAYS DATE: _____

Medicare Wellness Visit

Dear Patient,

Your Medicare benefits include an Annual Wellness Visit to assist in preventing illness or detect illness at an early stage. Your Annual Wellness Visit is a free benefit from Medicare. During this visit, the provider will:

- Concentrate on preventative medicine.
- Focus on identifying factors that may represent risk for future medical problems. The provider will work with you to reduce these risks.
- Review your medical history, medications, and confirm the names of any other medical providers you see.
- Work with you to establish a personal prevention plan in an effort to prevent or identify medical problems.

*** This Wellness visit is provided without any cost to you, but does not include the cost of medical treatment and is not the same as an “annual physical exam”. If medical treatment is provided, your insurance may require an office co pay may applied to the visit. If needed, a follow-up appointment will be scheduled to address any additional issues of concerns. **

_____ _____

Patient Signature Date

AIKEN Physicians Alliance

MEDICARE ANNUAL WELLNESS EXAM

PATIENT DEMOGRAPHICS

NAME: _____ DOB: _____ DATE:_____

HOME ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

HEALTH MAINTENANCE

Please record the last year you had the following. If you do not know, leave blank

HepB	_____/_____/_____	Echocardiogram	_____/_____/_____
Flu Vaccine	_____/_____/_____	Eye Exam	_____/_____/_____
Pneumonia Vaccine.....	_____/_____/_____	Hearing Exam	_____/_____/_____
Td/TDaP Vaccine	_____/_____/_____	Hemocult	_____/_____/_____
Zostavax (shingles)	_____/_____/_____	Pap/Pelvic Exam	_____/_____/_____
Abdominal Aortic Aneursym Screening	_____/_____/_____	Prostate Exam	_____/_____/_____
Mammogram	_____/_____/_____	Rectal Exam	_____/_____/_____
Bone Density	_____/_____/_____	Colonoscopy	_____/_____/_____
COVID – 19 Vaccine/Booster.....	_____/_____/_____	_____/_____/_____	_____/_____/_____

ADVANCE CARE DIRECTIV

Do you have a living will? ..... YES NO

Do you have a medical power of attorney? ..... YES NO

PHQ-9 DEPRESSION SCREENING

Over the past two weeks, how often have you been bothered by any of the following problems? (Circle One)

1. Not at all	2. Several Days	3. More than 1/2 days	4. Nearly Everyday

1)	Little interest or pleasure in doing things?.....	1	2	3	4
2)	Feeling down, depressed or hopeless?	1	2	3	4
3)	Trouble falling/staying asleep/sleeping too much?	1	2	3	4
4)	Feeling tired or having little energy?.....	1	2	3	4
5)	Poor appetite or overeating?	1	2	3	4
6)	Feeling bad about yourself?	1	2	3	4
7)	Trouble concentrating on things?.....	1	2	3	4
8)	Moving/speaking slowly or fidgety/restless?.....	1	2	3	4
9)	Thoughts that you would be better off dead or hurting yourself in anyway?	1	2	3	4

VISION SCREENING

Do you use Corrective lenses? ..... None Glasses Contact lenses

Surgical

HEALTH RISK SCREENING

Please use the number key to answer the following questions or answer YES NO by Circling your answer

1.Excellent	2.Very Good	3.Good	4. Fair	5.Poor

1. In general how is your health? 1 2 3 4 5
2. How is the condition of your mouth and teeth? 1 2 3 4 5
3. How is your eyesight? 1 2 3 4 5
4. How is your hearing? 1 2 3 4 5

5. In the past 7 days, how much pain have you felt ..... None Some A lot
6. Are you a smoker? ..... YES NO
7. In the past four weeks, how many alcoholic beverages have you had? ..... 1 2 3 4 5+
8. Do you ever drive after drinking or ride with someone who has been drinking? YES NO
9. How many days did you exercise last week? ..... 1 2 3 4 5+
10. On the days you exercised, how long did you exercise? ..... 10-30 mins 30-60 mins
11. How intense is your typical exercise? ..... Light Moderate Heavy Very Heavy None
12. Do you eat three meals per day? ..... YES NO
13. How many servings of fruits and vegetables do you eat on a typical day? ... 1 2 3 4 5
14. How many servings of high fiber or whole grains do you eat on a typical day? 1 2 3 4 5
15. Do you need help from others with your everyday activities? (eating, grooming) YES NO
16. Do you need help from others with activities such as banking, laundry, food prep? YES NO
17. How often is stress a problem for you to handle? ..... All of the time Some of the time Never

In the past 4 weeks how often have you:

1. Almost all of the time	2. Most of the time	3. Some of the time	4. Never

18. Felt depressed or hopeless? 1 2 3 4
19. Felt little interest or pleasure in doing things? 1 2 3 4
20. Felt nervous, anxious or on edge? 1 2 3 4

21. Limited your activities with your family and friends due to your physical or emotional health? YES NO
22. Are you having any problems with your memory? ..... YES NO
23. Do you have someone available to help you if you were to become ill? ..... YES NO
24. Who is your support? ..... Spouse Family Friends
25. How often have you felt sleepy during the daytime ..... All days Most days Some days Never
26. How often do you awaken at night? ..... 3+ times Once Occasionally None
27. How many hours do you sleep on a typical night? ..... 8 hours 4-6 hours 0-4 hours
28. Are there any hazards in your home? (Loose rugs, poor lighting) ..... YES NO
29. Have you fallen 2 or more times in the past year? ..... YES NO
30. Are you afraid of falling or have balance problems? ..... YES NO
31. Do you have trouble taking your medications as prescribed? ..... YES NO
32. Are you having difficulty driving your car? ..... YES NO
33. Do you wear a seatbelt when you are in the car? ..... YES NO
34. Do you wear sunscreen, sun glasses? ..... YES NO
35. Do you have trouble paying for/affording your medications? ..... YES NO
36. Do you have trouble with incontinence? (Going to the bathroom) ..... YES NO