Partners in Family Care, PC
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MEDICARE INSURED PATIENTS ONLY
A WORD TO OUR PATIENTS ABOUT MEDICARE ANNUAL WELLNESS VISITS

Dear Patient;

We want you to receive wellness care – health care that may lower your risk of illness or injury. Medicare pays for some wellness care, but it does not pay for all the wellness care you might need. We want you to know about your Medicare benefits and how we can help you get the most from them.

The term "physical" is often used to describe wellness care. But Medicare *does not* pay for a traditional, head-to-toe physical. Medicare *does* pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:

- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check only your blood pressure, weight, and vision.
- Recommendations for other wellness services and healthy lifestyle changes.

Before your appointment, you will need to complete some forms; also, our staff will ask you some questions about your health.

A wellness visit does not deal with new or existing health problems. That would be a separate service and requires a separate appointment. Please let our scheduling staff know if you need the doctor's help with a health problem, or something else. We may need to schedule a separate appointment. *A separate charge applies to these services, whether provided on the same date or a different date than the wellness visit.*

We hope to help you get the most from your Medicare wellness benefits. Please contact us with any questions.

Sincerely,

Partners in Family Care, P.C.
Drs. Sauer, Leibensperger, Elway and McKnight

BRING INSURANCE CARDS AND ID AT THE TIME OF VISIT
Patient Name: _____
Date And Time of Appointment: _____

MEDICARE WELLNESS CHECKUP & HEALTH RISK ASSESSMENT

Please complete this checklist before seeing your doctor.

Your responses will help you receive the best health and healthcare possible.

Your Name: _____

Today's Date: _____

DOB: _____ **Age:** _____

1. During the past **four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a Bit
   - ☐ Extremely
2. During the past **four weeks**, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a Bit
   - ☐ Extremely
3. During the past **four weeks**, how much bodily pain have you generally had?
   - ☐ No Pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain
4. During the past **four weeks**, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely, or blue; got sick and must stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)
   - ☐ Yes, as much as I wanted
   - ☐ Yes, quite a bit
   - ☐ Yes, some
   - ☐ Yes, a little
   - ☐ No, not at all
5. During the past **four weeks**, what was the hardest physical activity you could do for at least two minutes?
   - ☐ Very heavy
   - ☐ Heavy
   - ☐ Moderate
   - ☐ Light
   - ☐ Very Light
6. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)
   - ☐ Yes ☐ No
7. Can you go shopping for groceries or clothes without someone's help?
   - ☐ Yes ☐ No
8. Can you prepare your own meals?
   - ☐ Yes ☐ No
9. Can you do your housework without help?
   - ☐ Yes ☐ No
10. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
    - ☐ No ☐ Yes
11. Can you handle your own money without help?
    - ☐ Yes ☐ No
12. During the past **four weeks**, how would you rate your health in general?
    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor
13. How have things been going for you during the past **four weeks**?
    - ☐ Very well; could hardly be better
    - ☐ Pretty well
    - ☐ Good and bad parts about equal
    - ☐ Pretty bad
    - ☐ Very bad; could hardly be worse
14. Are you having difficulties driving your car?
    - ☐ No
    - ☐ Sometimes
    - ☐ Yes, often
    - ☐ Not applicable, I do not use a car
15. Do you always fasten your seat belt when you are in a car?
    - ☐ Yes, usually
    - ☐ Yes, sometimes
    - ☐ No

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MEDICARE WELLNESS CHECKUP & HEALTH RISK ASSESSMENT

16. How often during the past **four weeks** have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up	☐	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐	☐
Trouble eating well	☐	☐	☐	☐	☐
Teeth or denture problems	☐	☐	☐	☐	☐
Problems using the telephone	☐	☐	☐	☐	☐
Tiredness or fatigue	☐	☐	☐	☐	☐

17. Have you fallen two or more times in the past year, or have had 1 fall within the last year that resulted in an injury?
    ☐ No ☐ Yes
18. Are you afraid of falling?
    ☐ No ☐ Yes
19. Are you a smoker?
    ☐ No
    ☐ Yes, and I might quit
    ☐ Yes, but I'm not ready to quit
20. Do you have a living will or advanced directive?
    ☐ Yes ☐ No
21. Do you have trouble hearing?
    ☐ No ☐ Yes
22. During the past **four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?
    ☐ No alcohol at all
    ☐ One drink or less per week
    ☐ 2-5 drinks per week
    ☐ 6-9 drinks per week
    ☐ 10 or more drinks per week
23. Do you exercise for about 20 minutes three or more days a week?
    ☐ Yes, most of the time
    ☐ Yes, some of the time
    ☐ No, I usually do not exercise this much
24. How confident are you that you can control and manager most of your health problems?
    ☐ Very confident
    ☐ Somewhat confident
    ☐ Not very confident
    ☐ I do not have any health problems
25. What is your race?
    ☐ White
    ☐ Black or African American
    ☐ Asian
    ☐ Native Hawaiian or other Pacific Islander
    ☐ American Indian or Alaskan Native
    ☐ Hispanic or Latino origin or descent
    ☐ Other
26. Do you have smoke detectors in your home?
    ☐ Yes ☐ No
27. Do you have grab bars in your bathroom?
    ☐ Yes ☐ No
28. Do you have handrails on your steps?
    ☐ Yes ☐ No
29. Do you have throw rugs in any hallways?
    ☐ Yes ☐ No
30. Do you have poor lighting in any rooms?
    ☐ No ☐ Yes
31. In the last **two weeks**, have you felt any of the following?
    Down ☐ No ☐ Yes
    Depressed ☐ No ☐ Yes
    Lack of motivation ☐ No ☐ Yes
32. How often do you have trouble taking medications the way you have been told to take them?
    ☐ I do not have to take medicine
    ☐ I always take them as prescribed
    ☐ Sometimes I take them as prescribed
    ☐ I seldom take them as prescribed
33. Have you been given any information to help you with the following:
    Hazards in your house that might hurt you?
    ☐ No ☐ Yes
    Keeping track of your medications?
    ☐ No ☐ Yes
34. Have you experienced urinary leakage in the past 12 months?
    ☐ No ☐ Yes

    Do you find this occurs rarely, frequently, or daily?
    ☐ No ☐ Yes

    Do you find this interferes with daily living and desire treatment?
    ☐ No ☐ Yes

Patient Health Questionnaire—PHQ-9

Name_____Date of Birth_____Today's Date_____

Over the last 2 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
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	Column Totals:			
Scoring for use by medical or behavioral health professional only:	Total Score (Sum of all columns)			

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**

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MEDICARE WELLNESS CHECKUP & HEALTH RISK ASSESSMENT

Additional Information needed for your Annual Wellness Visit

Please list all of the doctors you see	Type of doctor

List of **all** of your current medications including OTC medicines, supplements, and vitamins
If more space is needed – continue on back

	Dose

List of Preventative Testing done recently
(Such as mammogram, colonoscopy, PAP test, DEXA scan, eye exam, PSA, or other bloodwork)

	Date

List of recent immunizations?
(Such as Zostavax, Pneumovax, Flu, Tetanus, Hepatitis, shots for travel)

	Date

Thank you very much for completing your Annual Wellness Checkup. Please give the completed form to the Office Staff when you arrive for your visit.