Medicare Annual Wellness Visit

The Annual Wellness Visit is not the same thing as what many people often refer to as their "yearly physical exam". This service is covered once every 12 months. Medicare is very specific about what the "Annual Wellness Visit" includes and excludes.

At the Annual Wellness Visit, we will talk to you about your medical history, review your risk factors, and make a personalized prevention plan to help keep you healthy. It's the best way we have to prevent or delay medical issues before they become a problem. This visit does ***not*** include a hands-on exam or any testing that your doctor may recommend, nor does it include any discussion about any new or current medical problems, conditions, or medications. You may schedule another visit to address these issues ***or*** if time permits these issues may be addressed during this visit.

You will be provided with a Personalized Preventive Plan which will assist in preventing disease and disability based on your current health and risk factors.

We appreciate the trust you put in us to take care of your health care needs and hope that you will take advantage of this benefit to work with your physician in creating your personalized prevention plan.

It is extremely important that you understand if services are performed outside the scope of an Annual Wellness Visit, those services may be subject to Medicare's cost-share and deductible charges.

Please acknowledge that you have read and understand the information by signing below.

Printed Name ______________________________ Date ____________________

Signature ______________________________

Name: ______________________ DOB: ____________ Appt date: ____________

Annual Wellness Visit Assessment—Dixie Primary Care

To help us understand your overall well-being, we gather important information about your health at each annual wellness visit. Thank you for answering these questions in preparation for your visit!

1. How would you rate your overall health?
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
   - ☐ Very Poor
2. How would you rate the trend of your overall health?
   - ☐ Getting better
   - ☐ Staying the same
   - ☐ Getting worse
3. Please answer YES or NO to the following:

   Are you experiencing anxiety or depression?
   ☐ Yes ☐ No

   Are you feeling increased stress?
   ☐ Yes ☐ No

   Are you experiencing social isolation?
   ☐ Yes ☐ No

   Are you feeling a lack of caregiver support?
   ☐ Yes ☐ No

   Are you a current smoker?
   ☐ Yes ☐ No

   Are you exposed to second-hand smoke?
   ☐ Yes ☐ No

   Are you unable to take any medications?
   ☐ Yes ☐ No

   Would you say you are physically inactive?
   ☐ Yes ☐ No

   Do you lack a balanced diet?
   ☐ Yes ☐ No

   Is your access to food / nutrition inadequate?
   ☐ Yes ☐ No

   Do you drink 4 or more alcoholic drinks in a day?
   ☐ Yes ☐ No

   Do you engage in recreational drug use?
   ☐ Yes ☐ No
4. How often do you exercise for 20 minutes 3 or more times in a week?
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ Less frequently
   - ☐ Not at all
5. Are you able to bathe, walk, and use the toilet without assistance?

   ☐ Yes ☐ No

   If no, which activities require assistance (check all that apply)
   - ☐ Bathing
   - ☐ Walking
   - ☐ Using toilet
6. Are you able to go shopping, do housekeeping, handle finances, and take medications without assistance?

   ☐ Yes ☐ No

   If no, which activities require assistance (check all that apply):
   - ☐ Shopping
   - ☐ Housekeeping
   - ☐ Handling finances
   - ☐ Taking medications
7. Have you fallen in the past year?

   ☐ Yes ☐ No

   Do you feel unsteady when standing or walking?

   ☐ Yes ☐ No

   Do you worry about falling?

   ☐ Yes ☐ No
8. Which of the following statements best describes your experience related to falls in the past year?
   - ☐ No falls
   - ☐ One fall with injury
   - ☐ Two or more falls with injury
   - ☐ One fall without injury
   - ☐ Two or more falls without injury
9. Have you been given any information to help you with hazards in your home that might hurt you?

   ☐ Yes ☐ No

   If yes: ______________________
10. Over the past 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

Name: ________________________ DOB: ______________

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

11. Current Medical Providers (that regularly provide care)

Provider Name	Specialty

12. During the past 12 months, how often has confusion or memory loss interfered with your ability to work, volunteer, or engage in social activities?
    - ☐ Always
    - ☐ Usually
    - ☐ Sometimes
    - ☐ Rarely
    - ☐ Never

13. Do you have any problems with your vision? (check all that apply)
    - ☐ No Vision Problems
    - ☐ Wear Glasses/Contact
    - ☐ Legally Blind
    - ☐ Assistance Needed with Vision Problems
    - ☐ Other ______________________________

14. Do you have any problems with your hearing? (check all that apply)
    - ☐ No Hearing Problems
    - ☐ Partial Hearing Loss
    - ☐ Deaf
    - ☐ Use Assistive Devices: ________________
    - ☐ TTY Used
    - ☐ Assistance Needed with Hearing Problems
    - ☐ Other: ____________________________

15. Personal Preventive Plan Services (PPPS)
    Check each item that has been completed and enter the date (Mo./Yr.) when it was last done (to the best of your knowledge):

☐ Flu shot	________	date completed
	________	next due
☐ Pneumococcal 23	________	date completed
	________	next due
☐ Prevnar 13	________	date completed
	________	next due
☐ Zoster-Shingles shot	________	date completed
	________	next due
☐ Bone Density Scan	________	date completed
	________	next due
☐ Colonoscopy	________	date completed
	________	next due
☐ AAA (Abdominal Aortic	________	date completed
Aneurysm) Screening	________	next due
☐ Advance Directive	________	date completed
	________	next due
☐ Eye Exam	________	date completed
	________	next due
☐ Mammogram	________	date completed
	________	next due
☐ Pap Smear	________	date completed
	________	next due
☐ PSA	________	date completed
	________	next due
☐ Prostate Exam	________	date completed
	________	next due