Medicare Annual Wellness Visit

Medicare has now introduced an Annual Wellness Visit. This is a chance to develop and update a personalized prevention plan based on your current health and risk factors. This will include a few of the standard elements of a routine visit such as updating your medical history, family history, update medications, specialist seen, and vitals. This is **NOT** a physical and will not include an examination. The purpose of this visit is to go beyond what can be done in the context of a normal visit and focus on other elements important to your health. Factors including: home safety, your fall risk, your ability to achieve your activities of daily living, memory screening, depression screening, and end of life planning. Medicare has realized the importance of these additional risk factors and offers this service once yearly with no cost to the patient.

THIS PACKET MUST BE COMPLETED BEFORE YOUR APPOINTMENT. IF IT IS NOT COMPLETED AT THE TIME OF YOUR APPOINTMENT WE WILL NEED TO RESCHEDULE YOUR APPOINTMENT.

IF YOU NEED ASSISTANCE PLEASE CALL BEFORE YOUR APPOINTMENT 352-205-4302

MEDICARE WELLNESS CHECKUP

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

Your name: ______________________________

Today's date: ______________________________

Your date of birth: ______________________________

1. What is your age?

☐ 65-69. ☐ 70-79. ☐ 80 or older.

2. Are you a male or a female?

☐ Male. ☐ Female.

3. 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.

4. 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.

5. During the **past four weeks**, how much bodily pain have you generally had?

☐ No pain.
☐ Very mild pain.
☐ Mild pain.
☐ Moderate pain.
☐ Severe pain.

6. 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 had to 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.

7. 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.

8. 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.

9. Can you go shopping for groceries or clothes without someone's help?

☐ Yes. ☐ No.

10. Can you prepare your own meals?

☐ Yes. ☐ No.

11. Can you do your housework without help?

☐ Yes. ☐ No.

12. 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?

☐ Yes. ☐ No.

13. Can you handle your own money without help?

☐ Yes. ☐ No.

14. During the **past four weeks**, how would you rate your health in general?

☐ Excellent.
☐ Very good.
☐ Good.
☐ Fair.
☐ Poor.

continued ➤

15. 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.

16. Are you having difficulties driving your car?

- ☐ Yes, often.
- ☐ Sometimes.
- ☐ No.
- ☐ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

18. 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.	☐	☐	☐	☐	☐

19. Have you fallen two or more times in **the past year**?

☐ Yes. ☐ No.

20. Are you afraid of falling?

☐ Yes. ☐ No.

21. Are you a smoker?

- ☐ No.
- ☐ Yes, and I might quit.
- ☐ Yes, but I'm not ready to quit.

22. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- ☐ 10 or more drinks per week.
- ☐ 6-9 drinks per week.
- ☐ 2-5 drinks per week.
- ☐ One drink or less per week.
- ☐ No alcohol at all.

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. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes. ☐ No.

Keeping track of your medications?

☐ Yes. ☐ No.

25. How often do you have trouble taking medicines 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.

26. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident.
- ☐ Somewhat confident.
- ☐ Not very confident.
- ☐ I do not have any health problems.

27. What is your race? (**Check all that apply.**)

- ☐ White.
- ☐ Black or African American.
- ☐ Asian.
- ☐ Native Hawaiian or other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

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Checklist of Activities of Daily Living (ADL)

Name:

Date of birth:

Check the level of function of each activity listed below. This will help us determine your functional status and how much assistance you may need.

Function	All by myself	With a little help	With a lot of help	I do not do
Bathing				
Dressing				
Grooming				
Oral care				
Toileting				
Transferring				
Walking				
Climbing stairs				
Eating				
Shopping				
Cooking				
Managing medications				
Using the phone				
Housework				
Doing laundry				
Driving				
Managing finances				

Home Safety Checklist

Name:
Date of birth:

Use this checklist to make sure that your home doesn't pose any health or safety hazards:

All Rooms:

- □ No loose carpeting or rugs that do not have a non-slip backing.
- □ Traffic areas free of furniture.
- □ Electrical cords and other wires taped against walls.
- □ Bright lighting with switches and all light bulbs in working order.
- □ Telephones placed on tables at a height that can be reached from the floor.

Stairs and Inclines: (write NA if no stairs or incline)

- □ Free of items.
- □ Plenty of room to move at top and bottom.
- □ No loose carpeting or edges to catch on.
- □ Handrails securely attached and at the proper height for user.
- □ Proper lighting on all steps, including switches at top and bottom of stairs.

Bathrooms:

- □ Grab bars near the tub, shower and toilet located and mounted properly.
- □ Non-slip surfaces in the tub or shower.
- □ Nightlight for when first entering the room.
- □ Rugs or bathmats with non-slip backing on the floor.
- □ Shower/tub bench or seat.

Bedrooms:

- □ Bedside table with non-tip lamp and room for eyeglasses.
- □ Clear traffic area from bedroom to bathroom.
- □ Comfortable, sturdy chair to aid in dressing.

Kitchen:

- □ Items placed where they can be reached without the use of a stool.
- □ Area to sit during food preparation.
- □ Flooring free of cracks, splits or up-turned edges.

Hearing Inventory — Screening Version

Name:

Date of birth:

Answer each question by checking the appropriate box "YES," "NO," or "SOMETIMES."	YES	NO	SOMETIMES
Does your hearing cause you to feel embarrassed when meeting new people?			
Does your hearing cause you to feel frustrated when talking to members of your family?			
Do you have difficulty hearing when someone speaks in a whisper?			
Do you feel held back by your hearing?			
Does your hearing cause you difficulty when visiting friends, relatives, or neighbors?			
Does your hearing cause you to attend religious services less often than you would like?			
Does your hearing cause you to have arguments with family members?			
Does your hearing cause you difficulty when listening to TV or radio?			
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
Does your hearing cause you difficulty when in a restaurant with relatives or friends?			

PHQ-2

Name:____________________________________ Date :_______________

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Yes	No
1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?	☐	☐
2. During the past month, have you often been bothered by little interest or pleasure in doing things?	☐	☐

Audit-C

1. How often do you have a drink containing alcohol?
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2 – 4 times per month
   - ☐ 2 – 3 times per week
   - ☐ 4 or more times per week

2. How many standard drinks containing alcohol do you have on a typical day?
   - ☐ 1 - 2
   - ☐ 3 - 4
   - ☐ 5 - 6
   - ☐ 7 - 9
   - ☐ 10 or more

3. How often do you have six or more drinks on one occasion?
   - ☐ Never
   - ☐ Less than monthly
   - ☐ Monthly
   - ☐ Weekly
   - ☐ Daily

Why is pre-planning for end of life decisions important?

It is not pleasant to think of not being able to make your own decisions. Imagine being so sick that you cannot communicate your wishes and desires such as seen with Terry Shivo. Even just riding in a car can lead to an unfortunate accident with serious medical injuries, it does not matter how old you are. One can never plan for something like this.

What we can do is plan who will make decisions for you if you cannot make them for yourself. That is what the technical term surrogate decision maker refers to. This person will not make any medical decisions for you unless you are unable to make the decisions yourself. Think of them as a safety net. You hope you never need it but just in case it is a good thing to have.

We ask you to think of someone who knows you well, cares for you, is able to make difficult decisions, and will be able to communicate your wishes. Your spouse maybe the person that knows you best but keep in mind that they are also the most likely to be riding with you in a car if you get in an accident and neither of you may be in any shape to make decisions. Just brainstorm between your friends and family members and see who you feel most confident with in this decision making role.

You can retract this at any time by updating the surrogate decision maker form. This form is also available on our website for download just make sure you notify our office so we can update your chart.

To help your surrogate decision maker know what you would want in certain situations we ask that you have an open discussion with them. This will provide your decision maker insight into what you would want and will help them respect your values. The following page provides some scenarios for which you can identify your wishes.

You can complete the following pages but please do not sign and date them until your appointment so our staff can serve as a witness.

Some additional resources for information are:

Five Wishes	http://www.agingwithdignity.org/five-wishes.php
Hospice	http://www.hospicefoundation.org/

Suggested form of a Health Care Surrogate, Florida Statutes Section 765.203

Designation of Health Care Surrogate

Name____

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Name ____
Street Address ____
City ______________________________ State ______ Zip ________________
Phone ____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name ____
Street Address ____
City ______________________________ State ______ Zip ________________
Phone ____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility

Additional Instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name ____
Name ____
Signed: ____

Witnesses 1. ____
2. ____

At least one witness must not be a husband or wife or a blood relative of the principal.

— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —

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