



MEDICARE WELLNESS VISITS PATIENT INFORMATION

Medicare Part B (Medical Insurance) covers:

- A **"Welcome to Medicare" preventive visit:** You can get this introductory visit only within the first 12 months you have Part B. This visit includes a review of your medical and social history related to your health and education and counseling about preventive services, including certain screenings, shots, and referrals for other care, if needed. It also includes:
 - **Prior to appointment, you should complete the Medicare Questionnaire** and then your provider will review the answers with you during this appointment.
 - Height, weight, blood pressure measurements and calculation of your BMI
 - Order any applicable screenings or vaccines
 - Review current medications and specialists, if applicable.
 - A review of your medical and family history

This visit is covered one time. You don't need to have this visit to be covered for yearly "Wellness" visits.

- **Yearly "Wellness" visits:** If you've had Part B for longer than 12 months, you can get this visit to develop or update a personalized prevention help plan to prevent disease and disability based on your current health and risk factors. Your provider will ask you to fill out a questionnaire, called a "Health Risk Assessment," as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit. It also includes:
 - **Prior to appointment, you should complete the Medicare Questionnaire** and then your provider will review the answers with you during this appointment.
 - Updating current medications and review of current specialists if applicable
 - Height, weight, blood pressure measurements and calculation of your BMI
 - A review of your medical and family history
 - Detection of any cognitive impairment
 - Order any appropriate screenings or vaccines

This visit is covered once every 12 months (11 full months must have passed since the last visit).

For further information about Medicare coverage for screenings, immunization, and other preventive services by going online at <https://www.medicare.gov/coverage/preventive-visit-and-yearly-wellness-exams.html>



Patient Name: _____

Date: _____

MEDICARE WELLNESS QUESTIONNAIRE

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health care possible.
(Use "✓" to indicate your answer)

1. What is your age?
 - 65-69
 - 70-79
 - 80 or older

2. Are you a male or 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? (*If Moderate, Quite a bit, or Extremely, patient needs to complete Patient Health Questionnaire*)
 - 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? (*If Moderate, Quite a bit, or Extremely, patient needs to complete Patient Health Questionnaire*)
 - Not at all
 - Slightly
 - Moderately
 - Quite a bit
 - Extremely

5. During the **past four weeks**, how much bodily pains have you generally had? (*If Moderate or Severe, patient needs to complete Patient Health Questionnaire*)
 - No pain
 - Very mild pain
 - Mild pain
 - Moderately 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 someone's 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? *(If Fair or Poor, patient needs to complete Nutritional Assessment)*
- Excellent
 - Very good
 - Good
 - Fair
 - Poor
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 the 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble eating well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth or denture problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems using the phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Have you fallen two or more times in the past year? *(If Yes, patient will need to complete Fall Prevention Home Assessment)*

- Yes
- No

20. Are you afraid of falling? *(If Yes, patient will need to complete Fall Prevention Home Assessment)*

- Yes
- No

21. Are you a smoker? *(If Yes, patient will need to complete Smoker's Home Assessment)*

- No
- Yes, and I might quit
- Yes, but I am 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 or less per week
- No alcohol at all

23. Do you exercise for about 20 minutes three or more day 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 medication?



- 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



PATIENT HEALTH QUESTIONNAIRE

Over the past 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Thoughts that you would be better off dead, or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

ADD COLUMNS: + +

(Healthcare Professional: For interpretation of TOTAL, please refer to score card) TOTAL:

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
If you checked off any problems, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



NUTRITIONAL ASSESSMENT

(Use "✓" to indicate your answer)

	YES	NO
I have an illness or condition that has made me change the kind and/or amount of food I eat	<input type="checkbox"/> 2	<input type="checkbox"/>
I eat fewer than two meals a day	<input type="checkbox"/> 3	<input type="checkbox"/>
I eat few fruits, vegetables, or milk products	<input type="checkbox"/> 2	<input type="checkbox"/>
I have three or more drinks of beer, liquor or wine almost every day	<input type="checkbox"/> 2	<input type="checkbox"/>
I have tooth or mouth problems that make it hard for me to eat	<input type="checkbox"/> 2	<input type="checkbox"/>
I do not always have enough money to buy the food I need	<input type="checkbox"/> 4	<input type="checkbox"/>
I eat alone most of the time	<input type="checkbox"/> 1	<input type="checkbox"/>
I take three or more different prescribed or over-the-counter drugs a day	<input type="checkbox"/> 1	<input type="checkbox"/>
Without wanting to, I have lost or gained 10 pounds in the past six months	<input type="checkbox"/> 2	<input type="checkbox"/>
I am not always physically able to shop, cook and/or fee myself	<input type="checkbox"/> 2	<input type="checkbox"/>

The scale above is scored as follows:

0-2 = Good nutrition. Recheck nutritional score in 6 months.

3-5 = Moderate nutritional risk. Improve eating habits and lifestyle. Recheck nutritional score in 3 months.

6 or more = High nutritional risk. Recommend intervention.



FALL PREVENTION HOME ASSESMENT

Any "NO" Answers Indicates a Need for Improvement
(Use "✓" to indicate your answer)

	YES	NO
BATHROOM		
1. Is the path from the bedroom to the bathroom well lit?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are there grab bars near the toilet and in the shower and bathtub?	<input type="checkbox"/>	<input type="checkbox"/>
3. If you have difficulty standing in the shower, do you use a shower seat?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are spills cleaned up immediately	<input type="checkbox"/>	<input type="checkbox"/>
5. Do your bathmats have slip-resistant backing?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you remove soap build in your shower/bathtub up to avoid slipping?	<input type="checkbox"/>	<input type="checkbox"/>
7. Can you reach soap in the shower without bending down or turning too far around?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have a raised toilet seat if you have difficulty standing up and sitting down?	<input type="checkbox"/>	<input type="checkbox"/>
KITCHEN	YES	NO
1. Are throw rugs/floor mats secure?	<input type="checkbox"/>	<input type="checkbox"/>
2. Can you get to regularly used items without bending down or reaching up too far?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are spills cleaned up immediately?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is food prepared at the kitchen table?	<input type="checkbox"/>	<input type="checkbox"/>
PORCH, YARD, OUTSIDE	YES	NO
1. Is the path from the house to the garage well lit?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are there cracks or buckles on the sidewalks or driveway?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are there hoses, weeds or other obstacles on the walkways?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are there icy steps or walkways?	<input type="checkbox"/>	<input type="checkbox"/>
BEDROOM	YES	NO



- | | | |
|---|--------------------------|--------------------------|
| 1. Is there a table close to your bed with a lamp and room to store eyeglasses and a phone? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are cords pushed back against the wall? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is there clutter on the floor | <input type="checkbox"/> | <input type="checkbox"/> |

LIVING AREAS

YES **NO**

- | | | |
|--|--------------------------|--------------------------|
| 1. Are floor coverings secure and sturdy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Can you answer the phone without getting up? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are cords pushed back against the wall? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Can you turn on a light without having to walk into a dark room? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have a step stool that has side rails, sturdy and in good condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have a cordless or cellular phone or an emergency alarm device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Is your floor free of clutter? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Is it easy to walk around the furniture in your home? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Can you pull cords to lights or ceiling fans without reaching up? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are there handrails on both sides of the stairways in your home? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are the steps on your stairways even and safe? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are there lights at the top and bottom of the stairs? | <input type="checkbox"/> | <input type="checkbox"/> |



SMOKER'S HOME ASSESSMENT

(Use "✓" to indicate your answer)

	YES	NO
Do you have working smoke detectors in your home/apartment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly change the batteries in your smoke detectors?	<input type="checkbox"/>	<input type="checkbox"/>
If you have space heaters, are they far away from flammable objects?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a fire extinguisher accessible in your house/apartment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a fire exit plan?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a working flashlight available for power outages?	<input type="checkbox"/>	<input type="checkbox"/>