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**Medicare Wellness Visit Packet**

**Your Annual Wellness Visit appointment is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_**

**What is the Annual Wellness Visit**?

* This visit is for talking with your healthcare team about your medical history, your risk for certain diseases, the current state of your health and your plan for staying well.
* We will measure your height, weight and blood pressure.
* We might refer you for screenings or services outside of the appointment.

**How is the Annual Wellness Visit different from other visits?**

* This is not the same as a yearly physical exam.
* We will not listen to your heart and lungs or check other parts of your body.
* You probably will not get lab work during this visit.
* You will need to schedule another appointment if you are not feeling well, concerned about a medical problem, or wanting to discuss medications or refills.

**When do I get it?**

You can receive a Wellness Visit (“Welcome to Medicare”) during the first 12 months you are enrolled in Medicare Part B. You can then schedule an Annual Wellness Visit once a year.

**Who pays for it?**

* Medicare will pay for the Annual Wellness Visit so you will have no out of pocket expense or copay.
* If you receive additional tests or services during the same visit that aren’t covered under these preventive benefits, you may have a co-pay and the Part B deductible may apply.

**Things to bring to your Annual Wellness Visit:**

Please complete all the forms in this packet and bring them to your visit including:

* List of medications as well as a bag of all medications including over-the-counter drugs, vitamins and herbals.
* The names and locations of the pharmacies you use.
* List of all medical providers.
* Record of previous immunizations and screening tests.
* List of all previous surgeries
* Health Risk Assessment
* Patient Health Questionnaire
* Hearing Screening
* Home Safety Assessment
* Copy of your completed Advanced Directive if you so desire.

We look forward to seeing you at your Annual Wellness Visit and creating your personalized prevention plan.

Annual Wellness Visit **Health Risk Assessment**

**MEDICARE WELLNESS CHECKUP**

Please complete this checklist before seeing your provider. Your responses will help you receive the best health care possible.

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

 Caucasian.

 Black or African American.

 Hispanic.

 American Indian.

 Other.

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?

 Never.

 Sometimes.

 Frequently.

 Always.

1. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

 Never.

 Sometimes.

 Frequently.

 Always.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Falling or dizzy when standing up. |  |  |  |  |  |
| Sexual problems. |  |  |  |  |  |
| Trouble eating well. |  |  |  |  |  |
| Teeth or denture problems. |  |  |  |  |  |
| Problems using the telephone. |  |  |  |  |  |
| Tiredness or fatigue. |  |  |  |  |  |

1. 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.  No.

Your name:

Today’s date:

Your date of birth:

Today’s date:

Your date of birth:

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

 Good.

 Fair.

 Poor.

1. How have things been going for you during the

**past four weeks**?

 Good.

 Fair.

 Poor.

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

 Very confident.

 Somewhat conﬁdent.

 Not conﬁdent at all.

1. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

 Heavy.

 Moderate.

 Light.

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

**Never**

**Seldom Sometimes**

**Often**

**Always**

1. During the past four weeks, how much bodily pain have you had?

 No pain.

 Mild pain.

 Moderate pain.

 Severe pain.

1. Do you exercise for about 20 minutes three or more days a week?

 Never.

 Sometimes.

 Frequently.

 Always.

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

 Yes.  No.

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

 Yes.  No.

1. Are you afraid of falling?

 Yes.  No.

1. 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.

1. 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.

1. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)

 Yes.  No.

1. Are you having difﬁculties driving your car?

 Yes.  No.

 Not applicable, I do not use a car.

1. Can you go shopping for groceries or clothes without someone’s help?

 Yes.  No.

1. Can you do your housework without help?

 Yes.  No.

1. Can you prepare your own meals?

 Yes.  No.

1. How often do you have trouble taking medicines the way you have been told to take them?

 Never.

 Sometimes.

 Frequently.

 Always.

1. Can you handle your own money without help?

 Yes.  No.

**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

**NAME:** **DOB:** **DATE:**

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

*(Circle the numbers to indicate your answer)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Not at all** | **Several days** | **More than half the days** | **Nearly**  **every day** |
| **1.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **2.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **5.** Feeling tired or having little energy | 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 |

**Add column answers together = TOTAL: \_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **10.** 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 people? Not difficult at all .  Somewhat difficult .  Very difficult .  Extremely difficult . |

**HEARING HANDICAP INVENTORY FOR THE ELDERLY SCREENING (HHIE-S)**

**NAME:** **DOB:** **DATE:**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| **1.** Are you having hearing problems? |  |  |

**Instructions: If you respond YES then please answer the further follow-up questions below.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **YES**  **(4 points)** | **SOMETIMES**  **(2 points)** | **NO**  **(0 points)** |
| **1.** Does a hearing problem cause you to feel embarrassed when meeting new people? | 4 | 2 | 0 |
| **2.** Does a hearing problem cause you to feel frustrated when talking to members of your family? | 4 | 2 | 0 |
| **3.** Do you have difficulty hearing when someone speaks in a whisper? | 4 | 2 | 0 |
| **4.** Do you feel handicapped by a hearing problem? | 4 | 2 | 0 |
| **5.** Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors? | 4 | 2 | 0 |
| **6.** Does a hearing problem cause you to attend religious services less often than you would like? | 4 | 2 | 0 |
| **7.** Does a hearing problem cause you to have arguments with family members? | 4 | 2 | 0 |
| **8.** Does a hearing problem cause you difficulty when listening to TV or radio? | 4 | 2 | 0 |
| **9.** Do you feel that any difficulty with your hearing limits or hampers your personal or social life? | 4 | 2 | 0 |
| **10.** Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? | 4 | 2 | 0 |

**Add column answers together = TOTAL: \_\_\_\_\_\_\_\_\_\_\_\_\_**

Interpretation of Score:

0-8 suggests no hearing handicap

10-24 suggests mild-moderate hearing handicap, consider referral

16-40 suggests significant hearing handicap, consider referral

**HOME SAFETY ASSESSMENT**

**NAME:** **DOB:** **DATE:**

|  |  |  |
| --- | --- | --- |
| **FLOORS** | **YES** | **NO** |
| 1. When you walk through a room, do you have to walk around furniture? |  |  |
| 2. Do you have throw rugs on the floor? |  |  |
| 3. Are there papers, books, towels, shoes, magazines, boxes, blankets, or other objects on the floor? |  |  |
| 4. Do you have to walk over or around wires or cords (like lamp, telephone, or extension cords)? |  |  |
| **STAIRS and STEPS** |  |  |
| 5. Are there papers, shoes, books or other objects on the stairs? |  |  |
| 6. Are some steps broken or uneven? |  |  |
| 7. Are you missing a light over the stairway? |  |  |
| 8. Do you have only one light switch for your stairs (only at the top or at the bottom of the stairs)? |  |  |
| 9. Has the stairway light bulb burned out? |  |  |
| 10. Is the carpet on the steps loose or torn? |  |  |
| 11. Are the handrails loose or broken? Is there a handrail on only one side of the stairs? |  |  |
| **KITCHEN** |  |  |
| 12. Are the things you use often on high shelves? |  |  |
| 13. Is your step stool unsteady? |  |  |
| **BATHROOMS** |  |  |
| 14. Is the tub or shower floor slippery? |  |  |
| 15. Do you need some support when you get I and out of the tub or up from the toilet? |  |  |
| **BEDROOMS** |  |  |
| 16. Is the light near the bed hard to reach? |  |  |
| 17. Is the path from your bed to the bathroom dark? |  |  |

**Remember to bring this packet with all forms attached with you to your Medicare Wellness Visit.**