HORIZON FAMILY MEDICINE, P.A.

Medicare Annual Wellness Visit Form

Please fill out this form and bring it with you on the day of your Annual Wellness Visit. This form contains your *confidential medical information*. Please keep it in a safe place. Should you choose to discard it, please discard it in a secure manner, such as shredding.
This form may be useful to bring if you have to go to the hospital, emergency room, or another physician.

[ ] Copy of form given to patient.

Date:
Medical Record #:
Patient Name:
Date of Birth:
Sex:
Ethnic Group:
Race :

Do you have a Living Will or other Advance Directive, or DNR signed? __Yes __ No
(If so, please provide us with a copy)

Have you designated a Durable Power of Attorney for Health Care? __Yes __ No
(If so, please provide us with a copy) If YES: Who is your Power of Attorney?

Discussed Advance Directives or gave information: [ ]
ADVANCE DIRECTIVES WE HAVE ON FILE:

Do you use seat belts when driving, or riding in a vehicle? __Yes __ No ___Sometimes

Have you been involved in a motor vehicle accident in the last year? __Yes __ No

<u>Eye Care:</u>
Who do you see for your eye care?
When did you last see your eye care professional (approximate date)?
Were there any concerns or problems with your eyes?
If it has been more than a year, why?

Do you have any concerns about your (check any that <u>are of concern</u>):
____ Memory
____ Balance
____ Safety
____ Hearing
___ Urinary health or concerns about bladder leakage
____ Vision
____ Sexual health
____ Mental health

If yes to any of these, what are your concerns?

<u>Functional status: MOBILITY:</u>

Do you require a cane, walker, motorized scooter, wheel chair or similar, to help with mobility?
____ Yes ____ No Please specify which device and why:

In the past year, have you fallen? ____ No ____ Yes
If yes, how many times?

If no, do you have concerns that there are times when you will fall?

If so, what causes this concern?

Have you had any injuries due to falling?

Which of the following can you do <u>without assistance</u>:

____ Take your own medication, get refills and take properly
_____ Manage your own health care
____ Handle your own finances
____ Drive a car
____ Shopping
____ Visit family and friends
____ Dress yourself
____ Prepare your own meals
____ Feed yourself
____ Toilet
____ Bathe
____ Laundry
____ Housework
____ Use a telephone
____ Use a television

If there are any of these that you need assistance with, ***which activities require assistance*? Please circle the tasks that require assistance.**

Who helps you do these activities?

<u>Functional Status: Exercise:</u>

During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
___ Very Heavy (such as running or moving heavy boxes)
___ Heavy (such as yard work)
___ Moderate (such as walking long distances or cleaning the whole house)
___ Light (such as light housework or walking short distances)
___ Very light (minimal activities)

How much exercise do you do in a week?
___ Every day
___ At least 20 minutes per day, 3 or more days per week
___ Not much daily exercise

Please provide us information for other health care providers and/or medical suppliers from whom you currently receive care, have received care in the last year, or from whom you have received prescriptions or devices:
1.

2.

3.

OTHER MEDICAL PROVIDERS listed in our records:

<u>TOBACCO USE</u>

Have you ever smoked? ___Yes ___ No
How many packs per day?
For how many years?
Have you used any other forms of tobacco (cigars, pipe, chew)?__Yes __ No
Have you quit using tobacco? __Yes __ No

If yes, when did you quit?

Have you considered quitting?__Yes __ No
Have you ever tried to quit?__Yes __ No

<u>ALCOHOL USE</u>
Do you drink alcohol? ___Yes ___ No
If yes, how much?
How often do you drink?
Have you ever felt you should cut down?

Have people annoyed you by criticizing your drinking?
Have you ever felt bad or guilty about your drinking?
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

PHQ-9 Questionnaire (Mood evaluation/Depression Screen)

Over the *last 2 weeks*, how often have you been bothered by the following:

*Please answer the following questions **using these numbers to answer**:*

Not at all =0
Several days in the past 2 weeks =1
More than half the days in the past 2 weeks =2
Nearly every day in the past 2 weeks =3

_____a. Little interest or pleasure in doing things.
_____b. Feeling down, depressed, or hopeless.
_____c. Trouble falling or staying asleep, sleeping too much.
_____d. Feeling tired or having low energy.
_____e. Poor appetite or overeating.
_____f. Feeling bad about yourself, that you are a failure, or have let yourself or your family down.
_____g. Trouble concentrating on things, such as reading the newspaper or watching television.
_____h. Moving or speaking so slowly that other people noticed. Or the opposite: being so fidgety or restless that you have been moving around a lot more than usual.
_____i. Thoughts that you would be better off dead, or of hurting yourself in some way.

Total: _____

If you checked off any problem on this questionnaire, 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

Do you feel that you are depressed?