Preventative Visit and Annual Wellness Exam

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 these:

- Certain screenings, shots, and referrals for other care, if needed
- Height, weight, and blood pressure measurements
- A calculation of your body mass index
- A simple vision test
- A review of your potential risk for depression and your level of safety
- An offer to talk with you about creating advance directives
- A written plan letting you know which screenings, shots, and other preventive services you need.

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. This plan is designed to help 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 can also include:

- A review of your medical and family history
- Developing or updating a list of current providers and prescriptions
- Height, weight, blood pressure, and other routine measurements
- Detection of any cognitive impairment
- Personalized health advice
- A list of risk factors and treatment options for you
- A screening schedule (like a checklist) for appropriate preventive services. Get details about coverage for screenings, shots, and other preventive services
- Advance Care Planning.

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

Note: You pay nothing for the “Welcome to Medicare” preventive visit or the yearly “Wellness” visit. However, if your doctor or other health care provider performs additional tests or services during the same visit that aren’t covered under these preventive benefits, you will have to pay copay, and the Part B deductible will apply.
Name_________________________________  Date________________________

Age_________________________________  Marital Status____________________________

Level of Education________________________  Primary Language Spoken_____________________

Race/Ethnicity__________________________  Interpreter Needed?__________________________

Gender ________________________________

Providers and Suppliers of Medical Care:  ________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

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General Health Status

1. In general, would you say your health is
   □ Excellent  □ Very Good  □ Good  □ Fair  □ Poor

2. 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

3. Were you hospitalized, in the Emergency Department, or had surgery in the last 12 months?
   □ Yes
   □ No

4. Do you consider yourself frail? (unintentional weight loss, low energy, muscle weakness etc.)
   □ Yes
   □ No

5. In the past 7 days, how much pain have you felt?
   □ No pain
   □ Very mild pain
   □ Mild pain
   □ Moderate pain
   □ Severe pain

6. Do you have any tooth, denture, or oral problems?
   □ Yes
   □ No

7. Each night, how many hours of sleep do you usually get?
   □ < 4 hours
   □ 5-6 hours
   □ 6-8 hours
   □ > 9 hours

8. Do you snore or has anyone told you that you snore?
   □ Yes
   □ No

9. In the past 7 days, how often have you felt sleepy during the daytime?
   □ Always
   □ Usually
   □ Sometimes
   □ Rarely
   □ Never

10. Do you have concerns regarding your sexual health?
    □ Yes
    □ No
Living Situation

11. What is your current living situation?
☐ Lives alone
☐ Lives with spouse
☐ Lives with significant other
☐ Lives with relative
☐ Lives with friend
☐ Lives in a nursing home
☐ Lives in an assisted living
☐ Homeless
☐ Lives with caregiver
☐ Disabled dependent
☐ Other: ___________________________________

12. During the past 4 weeks, was someone available to help you if you needed and wanted help?
☐ Yes, as much as I wanted
☐ Yes, quite a bit
☐ Yes, some
☐ Yes, a little
☐ No, not at all

13. In a typical week, how many times do you get together or talk on the telephone with family and friends?
☐ Never
☐ Once a week
☐ 2 times a week
☐ 3 times a week
☐ More than 3 times a week

Coping with Stress and Anger

14. How often is stress a problem for you in handling your health?
☐ Never or rarely
☐ Sometimes
☐ Often
☐ Always

15. How often is stress a problem for you in handling your finances?
☐ Never or rarely
☐ Sometimes
☐ Often
☐ Always

16. How often is stress a problem for you in handling your family or social relationships?
☐ Never or rarely
☐ Sometimes
☐ Often
☐ Always

17. How often is stress a problem for you in handling your work?
☐ Never or rarely
☐ Sometimes
☐ Often
☐ Always

18. Do you manage feelings of anger well?
☐ Yes
☐ No

Dealing with Depression

19. Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please check one response for each question a through i.)

a) Little interest or pleasure in doing things?
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day

b) Feeling down, depressed, or hopeless?
☐ Not at all
☐ Several days
☐ More than half the days
☐ Nearly every day
Dealing with Depression (continued)

c) Trouble falling or staying asleep, or sleeping too much?
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

d) Feeling tired or having little energy?
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

e) Poor appetite or overeating?
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

f) Feeling bad about yourself—or that you are a failure or have let yourself or your family down?
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

g) Trouble concentrating on things, such as reading the newspaper or watching television?
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

h) 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?
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

i) Thoughts that you would be better off dead, or of hurting yourself in some way?
   - Not at all
   - Several days
   - More than half the days
   - Nearly every day

20. 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 other people?
   - Not difficult at all
   - Somewhat difficult
   - Very difficult
   - Extremely difficult

Dealing with Anxiety

21. Over the last 2 weeks, how often were you bothered by any of the following problems?
   (Please check one response for each question a through g.)

   a) Feeling nervous, anxious, or on edge
      - Not at all
      - Several days
      - More than half the days
      - Nearly every day

   b) Not being able to stop or control worrying
      - Not at all
      - Several days
      - More than half the days
      - Nearly every day
Smoking and Alcohol Assessment

22. In the last 30 days have you smoked tobacco, cigars, pipes, cigarettes, or hookahs?
   □ Yes
   □ No

23. In the last 30 days have you used snuff or chewing tobacco?
   □ Yes
   □ No

24. If you smoke or use smokeless tobacco, would you be interested in quitting within the next month?
   □ Yes
   □ No
   □ Not applicable

25. Are you exposed to secondhand smoke?
   □ Yes
   □ No

26. In the past 7 days, how many days did you drink alcohol?
   □ None
   □ 1-2 days
   □ 3-4 days
   □ 5-7 days

27. On days when you drank alcohol, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks on one occasion?
   □ Never
   □ Once during the week
   □ 2-3 times during the week
   □ More than 3 times during the week

Nutrition and Exercise Assessment

28. Do you eat fruits and vegetables every day?
   □ Yes
   □ No

29. Do you eat whole grain foods every day?
   □ Yes
   □ No

30. Do you eat fried or high in fat foods every day?
   □ Yes
   □ No

31. Do you drink sugar-sweetened beverages every day?
   □ Yes
   □ No

32. How many hours of exercise, including walking, do you get every day?
   □ None
   □ 20-30 minutes
   □ 30 minutes – 1 hour
   □ 1-2 hours
   □ >2 hours

33. How intense is your typical exercise?
   □ Light (like stretching or slow walking)
   □ Moderate (like brisk walking)
   □ Heavy (like jogging or swimming)
   □ Very heavy (like fast running or stair climbing)
   □ I am currently not exercising
### Functional Assessment

34. In the past 4 weeks did you need help from others to perform any of these everyday activities?
- Bathing
- Dressing
- Grooming
- Eating
- Walking
- Using the toilet
- None

35. In the past 4 weeks did you need help from others to take care of any of these chores?
- Laundry
- Housekeeping
- Preparing a meal
- Shopping
- Transportation
- Managing finances
- Managing own medications
- Using the telephone
- All
- None

### Safety Assessment

36. Do you use a seatbelt?
- Yes
- No

37. Are there smoke alarms in your living area?
- Yes
- No

38. Are there carbon monoxide alarms in your living area?
- Yes
- No

39. Do you have throw rugs on the floor?
- Yes
- No

40. Does your home have grab bars in the bathroom?
- Yes
- No

41. Does your home have handrails on the stairs?
- Yes
- No
- Not applicable

### Fall Assessment

42. Have you fallen 2 or more times in the past year?
- Yes
- No

43. Do you feel unsteady when walking?
- Yes
- No

44. What assistive device do you use?
- Bath bar/seat
- Raised toilet seat
- Cane
- Walker
- Wheelchair
- Other: __________________________
- None
Hearing Assessment

45. Do you strain or struggle to hear/understand conversations?
   - Yes
   - No

46. Do you have trouble hearing the television or radio when others do not?
   - Yes
   - No

Cognitive Risk Assessment

48. Do you have trouble remembering or recalling facts or events?
   - Yes
   - No

49. Do family members or caregivers report that you have difficulty remembering things?
   - Yes
   - No

End of Life Planning

50. Do you have an updated/current Living Will and Power of Attorney for Health Care or a legal guardian on file?
   - Yes
   - No