JAMISON
FAMILY MEDICINE
COMPLETE HEALTH & WELLNESS

9631 N Nevada St. Suite 210
Spokane, WA 99218
Phone (509)319-2430 * Fax (877)568-2402

Dear _____,

We have scheduled an **Annual Wellness** visit with _____ on _____. We wanted to advise you that Medicare has set very specific guidelines for this visit that may be different from physicals or wellness visits you have had in the past.

Your **Annual Wellness** visit is a time for you and your provider to review and update your health risk assessment, update any personal and/or family history, update your current specialists and suppliers list (if any), basic vitals, other routine measurements deemed appropriate based on medical history, assess cognitive function, update your personalized prevention plan including personalized health advice and appropriate referrals to health education or preventive counseling services/programs, and discuss your advance care planning (ACP).

*Discussion/management of an acute or chronic health condition/concerns will require a separate office visit on a different date, Medicare doesn't allow conditions to be addressed during your **Wellness** exam.

Please fill out the entire Health Risk Assessment form and **BRING TO YOUR APPOINTMENT**. Your healthcare provider will be reviewing this form with you during your visit.

PLEASE BRING IN A LIST OF YOUR MEDICATION, SPECIALISTS **(EX. CARDIOLOGIST, PULMONOGIST, ETC)**, AND A LIST OF ANY SURGERIES YOU HAVE HAD.

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MEDICARE WELLNESS Visit Health Risk Assessment

Name:_____

DOB: _____ Visit Date: _____

Provider Initials: _____

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

1. Is this your first Wellness visit?
   Yes _____ No _____

2. Are you a female or a male?
   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, a little
   ___ No, not at all

7. During the **past four weeks**, what was the hardest physical activity you could do for at least 2 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, 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

Can you do your housework without help?

_____ Yes _____ No

11. 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

12. Can you handle your own money without help?

_____ Yes _____ No

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

___ Excellent
___ Very good
___ Good
___ Fair
___ Poor

14. Do you have trouble hearing the television or radio when others do not?

_____ Yes _____ No

15. Do you have to strain or struggle to hear/understand conversations?

_____ Yes _____ No

16. 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

17. Are you having difficulties driving your car?

____ Yes, often
____ Sometimes
___ No

Name:_____

DOB:_____

18. Do you use your seatbelt 100 % of the time?

_____ Yes _____ No

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

Circle Answer

Falling or dizzy when standing up.
Never/Seldom/Sometimes/Often/ Always

Sexual problems
Never/Seldom/Sometimes/Often/ Always

Trouble eating well.
Never/Seldom/Sometimes/Often/ Always

Teeth or denture problems.
Never/Seldom/Sometimes/Often/ Always

Problems using telephone.
Never/Seldom/Sometimes/Often/ Always

Tiredness or fatigue.
Never/Seldom/Sometimes/Often/ Always

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

_____ Yes _____ No

21. Are you afraid of falling?

_____ Yes _____ No

22. Are you a smoker?

___Yes, and I might quit
___ Yes, but am not ready to quit
___ No

23. 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

24. 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

25. Have you been given any information to help you with the following:
    a. Hazards in your house that might hurt you?
    _____ Yes _____ No
    b. Keeping track of your medications?
    _____ Yes _____ No

26. How confident are you that you can control and manage most of your health problems?
____ Very confident
____ Somewhat confident
____ Not very confident

28. How often do you have trouble taking medicines the way you have been told to take them?
____ I always take them as prescribed
____ Sometimes I take them as prescribed
____ I seldom take them as prescribed
____ I do not have to take medicine

Clock Drawing must be completed in the office at time of visit.

27. Clock Drawing Test (A new standardized Medicare Assessment Tool.)
    1. Please draw a clock below
    2. Draw the clock face
    3. Draw the numbers in the correct position
    4. Draw the clock hands to show the time of 11:10

Patient Name: _____ DOB: _____

Th*ank you very much for completing your Medicare Wellness Assessment. Please give the completed form to the front office staff or medical assistant.*

Mood Scale (PHQ)

Over the <u>last two weeks</u>, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

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 other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Score: _____

POSITIVE/NEGATIVE

Plan:_____

_____

_____

I agree to release the results of this mood evaluation questionnaire to my referring doctor or family doctor.

Signature_____ Date_____

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Patient Name: _____
DOB: _____

Below are Medicare preventative services you *may* be eligible for, to help us coordinate your personalized prevention plan complete the following history (if exact date is unknown, please list an approximate date);

PLEASE CIRCLE

□ **Bone density test (DEXA):** YES NO REFUSE

Exam date _____ Exam location _____

□ **Colorectal cancer screening:** YES NO REFUSE

Exam date _____ Exam location _____

□ **Mammogram (breast cancer screening):** YES NO REFUSE

Exam date _____ Exam location _____

□ **Eye Exam/Glaucoma Screening**: YES NO REFUSE

Exam date _____ Exam location _____

□ **Lung cancer screening (current/former smoker):** YES NO REFUSE

Exam date _____ Exam location _____

□ **Pneumococcal (pneumonia) shot:** YES NO REFUSE

Exam date _____ Exam location _____

□ **Prostate Screening (Male only):** YES NO REFUSE

Exam date _____ Exam location _____

□ **Flu shot in the last 12 months:** YES NO REFUSE

Exam date _____ Exam location _____