Comprehensive Medical Care of Danbury

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MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Providers and Suppliers of Your Medical Care:

Please list all providers and suppliers of your medical care such as primary care physicians, specialty physicians, chiropractors, pharmacies, herbalists and therapists.

Primary Care Physician(s)	Specialty
Other Patient Care Team members	**Specialty**

MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Current Medications:

Please include prescriptions, over-the counter medications, vitamins and supplements.

Medication name	Dose	Route	Frequency

Medication Allergies:

Medication	Reaction

DAILY ASPIRIN USE

Have you discussed taking a daily aspirin with your doctor?

___Yes

___No

MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Your History: Please check the appropriate box for the conditions as they apply to you:

Medical History

Condition	yes	no	Comments		Condition	yes	no	Comments		Condition	Yes	No	comments
Allergies					Depression					Heart Attack (Myocardial infarction)			
Anemia					Diabetes					Nerve/muscle disease			
Anxiety					Emphysema					Osteoporosis			
Arthritis					Reflux, Heartburn (GERD)					Seizures			
Asthma					Glaucoma					Sickle cell anemia			
Blood transfusion					Heart murmur					Stroke			
Cancer					HIV/AIDS					Substance abuse			
Cataracts					High Blood Pressure (Hypertension)					Thyroid disease			
Heart Failure (CHF)					Kidney disease					Tuberculosis			
Clotting disorder					Meningitis					Ulcers			
Chronic obstructive lung disease (COPD)													

Other Medical History:

MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Surgical History: Female

Surgery	Yes	No	Comments		Surgery	Yes	No	Comments		Surgery	Yes	No	Comments
Appendectomy					Cosmetic surgery					Joint replacement			
Brain surgery					C-Section					Small intestine surgery			
Breast Surgery					Eye surgery					Spine surgery			
Gall Bladder Surgery (Cholecystectomy)					Fracture surgery					Tubal Ligation			
Colon surgery					Hernia repair					Heart Valve Replacement			

Surgical History: Male

Surgery	Yes	No	Comments		Surgery	Yes	No	Comments		Surgery	Yes	No	Comments
Appendectomy					Cosmetic surgery					Prostate surgery			
Brain surgery					Eye surgery					Small intestine surgery			
Heart Bypass					Fracture surgery					Spine surgery			
Gall Bladder Surgery (Cholecystectomy)					Hernia repair					Heart Valve Replacement			
Colon surgery					Joint replacement					Vasectomy			

Other surgical history:

MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Family History: Please check the appropriate box of the conditions that apply to your blood relatives:

Relation	Name	Alive	Deceased	Alcohol abuse	Arthritis	Asthma	Birth Defects	Cancer	Chronic Obstructive lung disease (COPD)	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Learning Disability	Mental illness	Mental Retardation	Miscarriages	Stroke	Vision loss
Mother																								
Father																								
Sister																								
Brother																								
Daughter																								
Son																								

Family history comments:

MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE
Social History:

Alcohol Use

___Yes ___ No

If Yes: ____ number of drinks per week

If Yes: _____type(s) of alcoholic beverages

Sexually Active

___Yes ___No __Not currently

If Yes: Circle appropriate responses

Partner(s)**:** Male Female

If Yes: Birth control/Protection used_____

Drug Use

___Yes ___No

If Yes: ____ number of times used per week

If Yes: list type(s) of recreational drugs used _____

Tobacco Use

___Yes ___No

Complete appropriate responses below:

____ Current Every day Smoker? _____ Number of packs per day _____ Number of Years

____ Current Smoker?(not daily) _____ Number of packs per week _____ Number of Years

____ Former Smoker? _____ Quit date

____ Passive Smoker?

Are you ready to Quit? ___ Yes ___ No

Smokeless Tobacco Use

___Yes ___No

Complete appropriate responses below:

____Former User? _____ Quit date

____Never Used

Are you ready to Quit? ___ Yes ___ No

MEDICARE ANNUAL WELLNESS HEALTH RISK ASSESSMENT

BEHAVIORAL RISK FACTORS

PHYSICAL ACTIVITY

How many days a week do you usually exercise?
_____ days per week.

On days when you exercise, for how long do you usually exercise?
_____ minutes per day
_____ does not apply

How intense is your typical exercise? (Check one)
___ 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

NUTRITION

On a typical day, how many servings of fruits and/or vegetables do you eat? (1 serving= 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit, 1 cup=size of a baseball)
___ servings per day

On a typical day, how many servings of high fiber or whole grain foods do you eat? (1 serving=1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal. Or ½ cup of cooked brown rice or whole wheat pasta)
___servings per day

On a typical day, how many servings of fried or high-fat foods do you eat? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese or mayonnaise)
___servings per day

ORAL HEALTH

How often do you brush your teeth?
___At least once daily
___Most days of the week
___Seldom
___Never

Do you visit the dentist regularly?
___Yes
___No

MEDICARE ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT

MOTOR VEHICLE SAFETY

Do you always fasten your seat belt when you are in the car?

___Yes

___No

Do you ever drive after drinking, or ride with a driver who has been drinking?

___Yes

___No

SUN EXPOSURE

Do you protect yourself from the sun when you are outdoors?

___Yes

___No

BIOMETRIC MEASURES

BLOOD PRESSURE

If your blood pressure was checked within the past year, enter the actual result, or check the appropriate response on the lines below for each column:

_____ Desirable (at or below 120/80)
_____ Borderline high (120/80 to 139/89)
_____ High (140/90 or higher)
_____ Don't know/not sure
_____ Does not apply

CHOLESTEROL

If your cholesterol was checked within the past year, enter the actual result, or check the appropriate response on the lines below for each column:

Total	HDL	LDL	Triglycerides
_____ Desirable (Below 200)	_____ Desirable (Above 50)	_____ Desirable (Below 130)	_____ Desirable (Below 150)
____ Borderline high (200-239)	____ Borderline low (40-50)	_____ Borderline high (130-160)	_____ Borderline high (150-200)
_____High (240 or higher)	_____ Low (40 or less)	_____ High (160 or higher)	_____ High (200 or higher)
_____ Don't know/not sure	_____ Don't know/not sure	_____ Don't know/not sure	_____ Don't know/not sure
_____ Does not apply	_____ Does not apply	_____ Does not apply	_____ Does not apply

MEDICARE ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT

BIOMETRIC MEASURES continued:

BLOOD GLUCOSE

If your glucose was checked within the past year, enter the actual result, or check the appropriate response on the lines below for each column:

_____ Desirable (Below 100)
_____ Borderline high (100-125)
_____ High (126 or higher)
_____ Don't know/not sure
_____ Does not apply

Have you ever been told by a doctor or a health professional that you have diabetes or high blood sugar?

___Yes

___No (skip to next section)

If you have had your hemoglobin A1c level checked within the past year, enter the actual result, or check the appropriate response on the lines below for each column:

_____ Desirable (7 or lower)
_____ Borderline high (7-8)
_____ High (8 or higher)
_____ Don't know/not sure
_____ Does not apply

OVERWEIGHT/OBESITY

What is you height? Example: 5 feet, 6 inches= 5'6"

_____Feet, _____inches

What is your weight?

_____Pounds

MEDICARE ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT

PSYCHOSOCIAL RISK FACTORS

DEPRESSION

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

___Almost all of the time
___Most of the time
___Some of the time
___Almost never

Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?

___Almost all of the time
___Most of the time
___Some of the time
___Almost never

Have your feelings caused you distress or interfered with your ability to interact socially with friends?

___Yes
___No

During the past 6 months, how often have you felt sad or depressed?

___Almost all of the time
___Most of the time
___Some of the time
___Almost never

In general, how satisfied are you with your life?

___Very satisfied
___Satisfied
___Dissatisfied
___Very dissatisfied

STRESS/ANGER

How often is stress/anger a problem for you?

___Never, rarely
___Sometimes
___Often
___Always

How well do you handle the stress/anger in your life?

___I'm usually able to cope effectively
___At times I have problems coping
___I often have problems coping

MEDICARE ANNUAL WELLNESS VISIT HEALTH RISK ASSESSMENT

GENERAL WELL-BEING

In general, would you say your health is?

___Excellent
___Very good
___Good
___Fair
___Poor

SOCIAL/EMOTIONAL SUPPORT

How often do you get the social and emotional support you need:

___Always
___Usually
___Sometimes
___Rarely
___Never

PAIN/FATIGUE

How many hours of sleep do you usually get each night?

_____hours

Do you have pain that interferes with performing desired activities?

___Yes
___No

How often do you feel unusually tired?

___Never, rarely
___Sometimes
___Often
___Always

MEDICARE ANNUAL WELLNESS VISIT FUNCTIONAL ASSESSMENT

HEARING IMPAIRMENT

Do people complain that you turn the TV volume up too high?
___Yes
___No

Do you find yourself asking people to repeat themselves?
___Yes
___No

Do you have trouble hearing in a noisy background?
___Yes
___No

ACTIVITIES OF DAILY LIVING

Do you need help with the telephone?
___Yes
___No

Do you need help eating, bathing, getting dressed or using the toilet?
___Yes
___No

Do you need help with shopping or preparing meals?
___Yes
___No

Do you need help with managing money or your medication?
___Yes
___No

FALL RISK ASSESSMENT

Have you fallen in the past year?
___Yes
___No

Do you feel unsteady when you walk?
___Yes
___No

Do you feel dizzy when you get up from a bed or chair?
___Yes
___No

MEDICARE ANNUAL WELLNESS VISIT FUNCTIONAL ASSESSMENT

HOME SAFETY

Does your home have rugs in the hallways?
___Yes
___No

Does your home have grab bars in the bathroom?
___Yes
___No

Is there any clutter in your walking space at home?
___Yes
___No

MEMORY LOSS

Do family members report that you have difficulty remembering things?
___Yes
___No

END OF LIFE PLANNING

Do you have an Advance Directive, Living Will or Power of Attorney for Health Care (POA), in the case that an injury or illness causes you to be unable to make healthcare decisions?
___Yes
___No

Would you like further information regarding Advance Directives?
___Yes
___No

_____ _____
Patient signature **Date**

If completed by someone other than the patient:

_____ _____ _____ _____
Print Name **Signature** **Relationship to patient** **Date**

MEDICARE ANNUAL WELLNESS VISIT PHYSICIAN WORKSHEET

Vital signs:

B/P: _____ / _____ Ht: _____ Wt: _____ BMI: _____

Note: A physical exam is required if this is the Initial Preventive Physician Examination (G0402) performed in the first 12 months of Medicare enrollment. It is not part of the Annual Wellness Visit (G0438/G0439); bill an office visit with a -25 modifier if E/M services are provided with an AWV.

Physical Exam:

Constitutional:

Eyes:

ENM:

Neck:

Resp:

CV:

Chest / Breast:

GI / Abd:

GU – Male / Female:

Lymph:

Psych:

Skin:

Neuro:

MS:

MEDICARE ANNUAL WELLNESS VISIT PHYSICIAN WORKSHEET

Mini-Cog test

1. Word recollection (Banana, Sunrise, Chair)
   Have patient repeat the 3 words, tell them to remember them.

2. Clock drawing
   Give the following instructions.
   1. Draw a clock in the space below.
   2. Set the hands to show 11:10.

3. Word recollection
Ask patient to repeat the words in step 1.

Scoring:
_____1 point each word patient recalls
_____2 point for normal clock; 0 points for abnormal clock

_____Total Score

0 – 3 = possible impairment
3 – 5 = suggests no impairment

_____ _____

Provider Signature **Date**

MEDICARE ANNUAL WELLNESS VISIT

Risks based on review of HRA	Recommendations: risk/benefit

Other recommendations/personal health advice

PREVENTIVE SERVICES CHECK LIST

MEDICARE COVERED PREVENTIVE SERVICES

1. **Immunizations:**
   Influenza: Medicare provides coverage for one influenza vaccine per influenza season.

   Pneumococcal: Medicare provides coverage for Pneumococcal Polysaccharide Vaccine once in a lifetime, or if 5 years have passed since the last vaccination for some high risk persons.

   Hepatitis B virus: Medicare provides coverage for Hepatitis B Virus vaccine for certain individuals at medium to high risk for Hepatitis B.

2. **Cancer screening:**
   Male: Age 50 and older: Prostate (Annual PSA and Digital Rectal Exam)

   Female: Age 40 and older: Mammogram (Annual Screening Mammogram)

   Female: Pap/Pelvic Exam (Once every 24 months for low risk/Annually for high risk)

   Age 50 and older: Colorectal Screening, one of the following:
   - Annual fecal occult blood test
   - Flexible Sigmoidoscopy (Once every 4 years for high/low risk)
   - Colonoscopy (Once every 2 years high risk/Once every 10 years low risk)
   - Barium Enema (Once every 2 years high risk/ Once every 4 years low risk)

3. **Bone mass measurement:**
   Medicare providers coverage of bone mass measurement every 2 years for qualified individuals that must meet the medical indications for at least one of the following categories:
   (i)Estrogen-deficient woman; (ii)an individual with vertebral abnormalities; (iii)an individual receiving steroid therapy; (iv)an individual with known primary hyperparathyroidism; or (v)an individual receiving FDA-approved osteoporosis drug therapy.

4. **Screening for glaucoma:**
   Medicare provides coverage for glaucoma screening annually for eligible individuals in at least one of the high-risk groups: (i) individuals with diabetes mellitus; (ii) individuals with a family history of glaucoma; (iii) African-Americans age 50 and older; or (iv) Hispanic-Americans age 65 and over.

5. **Screening labs:**
   Diabetes: Medicare provides coverage for fasting glucose tests with the following frequency:
   i. A maximum of 2 diabetes screening tests within a 12-month period (but not less than 6 months apart) for individuals diagnosed with pre-diabetes.
   ii. One diabetes screening test within a 12-month period (at least 11 months have passed following the month in which the last Medicare-covered diabetes screening test was performed) for non-diabetic and not previously diagnosed with “pre-diabetes”.

   Cardiovascular: Medicare provides coverage of lipid panel once every 5 years with no signs or symptoms.

6. **Ultrasound screening for Abdominal Aortic Aneurysm (AAA):**
   Medicare provides a once in a lifetime benefit that meets one of the following risk factors: (i) Family history; or (ii) a man age 65-75 who has smoked at least 100 cigarettes in his lifetime. Individual cannot have had a previous ultrasound screening.

7. **Diabetes Self Management Training:**
   Medicare provides coverage for diabetes self management training. Coverage is for those who are at risk for complications from diabetes, recently diagnosed with diabetes, or previously diagnosed with diabetes.
   - Up to 10 hours within a continuous 12 month period
   - Two hours of follow-up in a calendar year

8. **Medical Nutritional Therapy:**
   Medicare provides coverage for medical nutritional therapy with a Registered Dietician, or medical nutritional professional. This could be for individual therapy, or group therapy.
   - First year – three hours of therapy
   - Subsequent year- two hours of therapy

9. **Smoking Cessation counseling:**
   Medicare provides coverage for smoking cessation counseling for those that have signs or symptoms of a smoking-related illness or have a history of smoking.
   - Eight visits within 12 months

☐ A copy of the Personal Prevention Plan was provided to the patient.

_____ _____

Provider Signature Date