MEDICARE WELLNESS CHECKUP

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

Your name: _____

Today's date: _____

Your date of birth: _____

1. What is your age?

☐ 65-69. ☐ 70-79. ☐ 80 or older.

2. Are you a male or a female?

☐ 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, some.
☐ 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 two 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 or 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.

11. Can you do your housework without help?

☐ Yes. ☐ No.

12. 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.

13. Can you handle your own money without help?

☐ Yes. ☐ No.

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

☐ Excellent.
☐ Very good.
☐ Good.
☐ Fair.
☐ Poor.

continued ➤

15. 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.

16. Are you having difficulties driving your car?

- ☐ Yes, often.
- ☐ Sometimes.
- ☐ No.
- ☐ Not applicable, I do not use a car.

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

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

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

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	☐	☐	☐	☐	☐
Sexual problems.	☐	☐	☐	☐	☐
Trouble eating well.	☐	☐	☐	☐	☐
Teeth or denture problems.	☐	☐	☐	☐	☐
Problems using the telephone.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

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

☐ Yes. ☐ No.

20. Are you afraid of falling?

☐ Yes. ☐ No.

21. Are you a smoker?

- ☐ No.
- ☐ Yes, and I might quit.
- ☐ Yes, but I'm not ready to quit.

22. 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.

23. 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.

24. 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.

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

- ☐ I do not have to take medicine.
- ☐ I always take them as prescribed.
- ☐ Sometimes I take them as prescribed.
- ☐ I seldom take them as prescribed.

26. 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.

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

- ☐ White.
- ☐ Black or African American.
- ☐ Asian.
- ☐ Native Hawaiian or other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Family Practice Management

MEDICARE PREVENTIVE PHYSICAL EXAM

Today's Date _____

☐ Initial Preventive Physical Exam (Welcome to Medicare Physical)	☐ Initial annual wellness visit	☐ Subsequent annual wellness visit	☐ Other
Patient name	Medical record #		Date of birth
Staff conducting initial intake	Date of last exam		Medicare B eligibility date
Language or other communication barriers: (describe)			Sex / LMP
Interpreter or other accommodation provided today: (describe)			Gravida/ para / Year of menopause

Vital signs	Ht	Wt	BMI	Waist	BP	Temp	P/R

SOCIAL HISTORY

Tobacco ☐ Current Type: Freq: ☐ 2nd hand ☐ Never ☐ Prior use Quit date:

ETOH ☐ Never ☐ Occasional ☐ Daily History of ETOH: (describe)

Caffeine ☐ Never ☐ Occasional ☐ Daily

Drug abuse ☐ Never ☐ Occasional ☐ Daily ☐ Prior use Quit date:
History of drug abuse: (describe)

Occupation | Exercise type/frequency

Home environment ☐ Private home ☐ Assisted living ☐ Other: (describe)

FAMILY HISTORY
use ✓ to indicate positive history

	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart disease									
Stroke									
Kidney disease									
Obesity									
Genetic disorder									
Alcoholism									
Liver disease									
Depression or manic depressive disorder									
Colon or rectal cancer									
Breast cancer									
Other cancer									
Other: _____									

Patient Name _____ Today's Date _____

MEDICAL HISTORY

Hospital visits since last office visit/reason	Facility	Attending physician	Date of hospital visit	Past surgeries (include date and description of any complications)

ALLERGY LIST

Allergies	Type of reaction

MEDICATION LIST

if noted elsewhere in chart, indicate location

Herbals, supplements, OTC drugs, substances of abuse	Date started	Date discontinued	Rx meds, dose, frequency, route	Date started	Date discontinued

PROBLEM LIST

Chronic problems	Date added	Managing physician (if other)	Date updated	Initial

continued ➤

Patient Name _____ Today's Date _____

PROBLEM LIST continued				
Acute problems (R=resolved)	Date added	Managing physician (if other)	Date updated	Initial

OTHER PHYSICIANS AND PROVIDERS OF CARE this documentation not required for IPPE		
Name & specialty/provider type	Type of care	Date discontinued

→ Physician/other provider sign here to indicate review/notation of pertinent history: _____

DEPRESSION SCREENING		
1. Over the past two weeks, has the patient felt down, depressed or hopeless?	☐ Yes	☐ No
2. Over the past two weeks, has the patient felt little interest or pleasure in doing things?	☐ Yes	☐ No

FUNCTIONAL ABILITY/SAFETY SCREENING		
1. Was the patient's timed Up & Go test unsteady or longer than 30 seconds?	☐ Yes	☐ No
2. Does the patient need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money?	☐ Yes	☐ No
3. Does the patient's home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting?	☐ Yes	☐ No
4. Have you noticed any hearing difficulties?	☐ Yes	☐ No
Hearing evaluation:		
A "yes" response to any of the above questions regarding depression or function/safety should trigger further evaluation.		

EVALUATION OF COGNITIVE FUNCTION this documentation not required for IPPE
Mood/affect
Appearance
Family member/caregiver input

Patient Name _____ Today's Date _____

VISION EXAMINATION

Visual acuity: L _____ R _____

ELECTROCARDIOGRAM REFERRAL OR RESULT

if performed/ordered (covered benefit for IPPE)

ADVICE/REFERRALS

based on history, exam and screening (including risks, interventions underway or planned, and benefits)

POTENTIAL RECOMMENDATIONS NOT COVERED AS MEDICARE PART B PREVENTIVE SERVICES

this documentation not required for IPPE

Patients should contact their Part D plan for information on preventive vaccines benefits.

Varicella vaccine	Aspirin therapy
Zoster vaccine (once)	Calcium supplement
Tdap vaccine (10 years)	Social services
Td vaccine (10 years)	Dietary counseling
MMR vaccine	
Meningococcal vaccine	
Hep A vaccine	

HANDOUTS REVIEWED AND DISCUSSED WITH PATIENT

continued ➤

Patient Name _____ Today's Date _____

Create two copies of this page: One for your charts and one to give to your patient.

COUNSELING AND REFERRAL OF OTHER PREVENTIVE SERVICES

(*Italic type* indicates deductible and co-insurance are waived.)

SERVICE	LIMITATIONS	RECOMMENDATION	SCHEDULED
Vaccines • Pneumococcal (once after 65) • Influenza (annually) • Hepatitis B (if medium/high risk)	Medium/high risk factors: End-stage renal disease Hemophiliacs who received Factor VIII or IX concentrates Clients of institutions for the mentally retarded Persons who live in the same house as a HepB virus carrier Homosexual men Illicit injectable drug abusers		
Mammogram (biennial age 50-74)	Annually (age 40 or over)		
Pap and pelvic exams (up to age 70 and after 70 if unknown history or abnormal study last 10 years)[1]	Every 24 months except high risk		
Prostate cancer screening (annually to age 75) Digital rectal exam (DRE) *Prostate specific antigen (PSA)*	Annually (age 50 or over), DRE not paid separately when covered E/M service is provided on same date		
Colorectal cancer screening (to age 75) • *Fecal occult blood test (annual)* • *Flexible sigmoidoscopy (5y)* • *Screening colonoscopy (10y)* • Barium enema			
Diabetes self-management training (no USPSTF recommendation)	Requires referral by treating physician for patient with diabetes or renal disease. 10 hours of initial DSMT sessions of no less than 30 minutes each in a continuous 12-month period. 2 hours of follow-up DSMT in subsequent years.		
Bone mass measurements (age 65 & older, biennial)	Requires diagnosis related to osteoporosis or estrogen deficiency. Biennial benefit unless patient has history of long-term glucocorticoid tx or baseline is needed because initial test was by other method.		
Glaucoma screening (no USPSTF recommendation)	Diabetes mellitus, family history African American, age 50 or over Hispanic American, age 65 or over		
Medical nutrition therapy for diabetes or renal disease (no recommended schedule)	Requires referral by treating physician for patient with diabetes or renal disease. Can be provided in same year as diabetes self-management training (DSMT), and CMS recommends medical nutrition therapy take place after DSMT. Up to 3 hours for initial year and 2 hours in subsequent years.		

Patient Name _____ Today's Date _____

SERVICE	LIMITATIONS	RECOMMENDATION	SCHEDULED
Cardiovascular screening blood tests (every 5 years) • Total cholesterol • High-density lipoproteins • Triglycerides	Order as a panel if possible.		
Diabetes screening tests (at least every 3 years, Medicare covers annually or at 6-month intervals for prediabetic patients) • Fasting blood sugar (FBS) or glucose tolerance test (GTT)	Patient must be diagnosed with one of the following: • Hypertension • Dyslipidemia • Obesity (BMI ³30 kg/m2) • Previous elevated impaired FBS or GTT ... or any two of the following: • Overweight (BMI ³25 but <30) • Family history of diabetes • Age 65 years or older • History of gestational diabetes or birth of baby weighing more than 9 pounds		
Abdominal aortic aneurysm screening (once) • Sonogram	Patient must be referred through IPPE and not have had a screening for abdominal aortic aneurysm before under Medicare. Limited to patients who meet one of the following criteria: • Men who are 65-75 years old and have smoked more than 100 cigarettes in their lifetime • Anyone with a family history of abdominal aortic aneurysm • Anyone recommended for screening by the USPSTF		
HIV screening (annually for increased risk patients) • HIV-1 and HIV-2 by EIA, ELISA, rapid antibody test or oral mucosa transudate	Patient must be at increased risk for HIV infection per USPSTF guidelines or pregnant. Tests covered annually for patients at increased risk. Pregnant patients may receive up to 3 tests during pregnancy.		
Smoking cessation counseling (up to 8 sessions per year) • Counseling greater than 3 and up to 10 minutes • Counseling greater than 10 minutes	Patients must be asymptomatic of tobacco-related conditions to receive as a preventive service.		
Subsequent annual wellness visit	At least 12 months since last AWV		

Physician's signature: _____ Date: _____

1. Recommendation of American Cancer Society; see http://www.uspreventiveservicestaskforce.org/3rduspstf/cervcan/cervcanrr.htm#clinical for more information.