MEDICARE WELLNESS CHECKUP

☐ No, not at all.

Please complete this checklist before seeing your Your name: _ doctor or nurse. Your responses will help you receive the best health and health care possible. 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? 7. During the past four weeks, what was the hardest ☐ Female. ☐ Male. physical activity you could do for at least two minutes? 3. During the past four weeks, how much have you ☐ Very heavy. been bothered by emotional problems such as feeling ☐ Heavy. anxious, depressed, irritable, sad, or downhearted and \square Moderate. blue? ☐ Light. ☐ Not at all. ☐ Very light. ☐ Slightly. 8. Can you get to places out of walking distance without ☐ Moderately. help? (For example, can you travel alone on buses or ☐ Quite a bit. taxis, or drive your own car?) ☐ Extremely. ☐ Yes. □ No. 4. During the past four weeks, has your physical and 9. Can you go shopping for groceries or clothes without emotional-health limited your social activities with family someone's help? friends, neighbors, or groups? ☐ Not at all. □ No. ☐ Yes. ☐ Slightly. 10. Can you prepare your own meals? ☐ Moderately. ☐ Yes. □No. Quite a bit. ☐ Extremely. 11. Can you do your housework without help? 5. During the past four weeks, how much bodily pain ☐ Yes. □No. have you generally had? 12. Because of any health problems, do you need ☐ No pain. the help of another person with your personal care ☐ Very mild pain. needs such as eating, bathing, dressing, or getting ☐ Mild pain. around the house? ☐ Moderate pain. □No. ☐ Yes. ☐ Severe pain. 13. Can you handle your own money without help? 6. During the past four weeks, was someone available □ No. to help you if you needed and wanted help? ☐ Yes. 14. During the past four weeks, how would you rate (For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk your health in general? to; needed help with daily chores; or needed help just ☐ Excellent. taking care of yourself.) ☐ Very good. ☐ Good. ☐ Yes, as much as I wanted. ☐ Fair. ☐ Yes, quite a bit. Poor. ☐ Yes, some. ☐ Yes, a little.

continued >

15. How have things been going for weeks?	or you during the past	22. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?	
□ Very well; could hardly be long or pretty well. □ Good and bad parts about □ Pretty bad. □ Very bad; could hardly be to long or pretty bad.	equal.	 □ 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. 	
16. Are you having difficulties drivin☐ Yes, often.☐ Sometimes.☐ No.	ng your car?	23. Do you exercise for about 20 minutes three or modays a week? Yes, most of the time. Yes, some of the time.	
☐ Not applicable, I do not us	e a car.	☐ No, I usually do not exercise this much.	
17. Do you always fasten your seat in a car?	belt when you are	24. Have you been given any information to help you with the following:	
☐ Yes, usually. ☐ Yes, sometimes. ☐ No.		Hazards in your house that might hurt you?	
18. How often during the past four	waske have you	Keeping track of your medications? ☐ Yes. ☐ No.	
been bothered by any of the follow	Never do Beldom Seldom Sometimes was Often Always	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.	
Falling or dizzy when standing up.		☐ I seldom take them as prescribed.	
Sexual problems. Trouble eating well.		26. How confident are you that you can control and manage most of your health problems?	
Teeth or denture problems. Problems using the telephone. Tiredness or fatigue.		□ Very confident.□ Somewhat confident.□ Not very confident.□ I do not have any health problems.	
19. Have you fallen two or more tim ☐ Yes. ☐ No. 20. Are you afraid of falling? ☐ Yes. ☐ No. 21. Are you a smoker? ☐ No.	es in the past year?	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.	
☐Yes, and I might quit. ☐Yes, but I'm not ready to qu	it.	Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.	

Family Practice Management

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MEDICARE PREVENTIVE PHYSICAL EXAM

☐ Initial annual

wellness visit

Medical record #

Date of last exam

☐ Initial Preventive Physical Exam

Staff conducting initial intake

Patient name 🗧 🚋 🦈

(Welcome to Medicare Physical)

Language or other communication barriers: (describe)

То	day's Date
☐ Subsequent annual wellness visit	☐ Other
# 12 Page 12 P	Date of birth
am	Medicare B eligibility date
	Sex LMP

Interpreter or other accommodation provided today: (describe)	Gravida/	Year of
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Occupation Exercise type/frequency		45 TE
Home environment Private home Assisted living Other (describe)	第一种基础	· · · · · · · · · · · · · · · · · · ·
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Hypertension		,			*				1.
Heart disease					, ;	;			
Stroke .					1 212				ž .
Kidney disease		• .				:			4
Obesity	-				<i>i</i> .			٠.	F 2
Genetic disorder		É							· ·
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Liver disease	-	, ê			12 21				::::
Depression or manic depressive disorder			-		-	-			* * * .
Colon or rectal cancer			-			-			Ť.
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Chronic problems	Date added	Managing physician (if other)	Date updated	Initial
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Patient Name		Т	oday's Date	
	PROBLE	M LIST continued		
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OTHER PHYS	ICIANS	AND PROVIDERS OF CARE		
		on not required for IPPE		
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Physician/other provider sign here to indicate review	w/notati	ion of pertinent history:		
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Patient Name	Today's Date
VISIONEX	AMINATION
Visual acuity: L	R
	M REFERRAL OR RESULT
u performed/ordered	covered benefit for IPPE)
ADVICES	REFERRALS
based on history, examining screening (including ris	ks, interventions underway or planned; and benefits)
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POTENTIAL RECOMMENDATIONS NOT COVER Alhis documentation	DIAS MEDICARE PART BIPREVENTIVE SERVICES
	ratiomation 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	自己的对象,更强烈的基本。 (1) 的复数克勒尔
Meningococcal vaccine	
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HANDOUTS REVIEWED AN	D DISCUSSED WITH PARENT
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Patient Name	 Today's Date <u> </u>

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)	1		
• 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)	Annually (age 50 or over), DRE not paid separately when covered E/M service is		
Digital rectal exam (DRE)	provided on same date		
Prostate specific antigen (PSA)			
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 rec-	Diabetes mellitus, family history		
ommendation)	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.		

SERVICE	LIMITATIONS	RECOMMENDATION	SCHEDULED
Cardiovascular screening blood tests (every 5 years)	Order as a panel if possible.		
Total cholesterol			
 High-density lipoproteins 			
Triglycerides			
Diabetes screening tests	Patient must be diagnosed with one of		
(at least every 3 years, Medicare	the following:		
covers annually or at 6-month inter- vals for prediabetic patients)	Hypertension		-
·	Dyslipidemia		
 Fasting blood sugar (FBS) or glu- cose tolerance test (GTT) 	Obesity (BMI ³ 30 kg/m2)		
cose tolerance test (or i)	Previous elevated impaired FBS or GTT		
	or any two of the following:		1
	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	Patient must be referred through IPPE and		
screening (once)	not have had a screening for abdominal		
Sonogram	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		ļ <u> </u>
HIV screening (annually for increased	Patient must be at increased risk for HIV		
risk patients)	infection per USPSTF guidelines or preg-		
 HIV-1 and HIV-2 by EIA, ELISA, 	nant. Tests covered annually for patients at increased risk. Pregnant patients may		
rapid antibody test or oral	receive up to 3 tests during pregnancy.		
mucosa transudate			
	·		
Smoking cessation counseling	Patients must be asymptomatic of		
(up to 8 sessions per year)	tobacco-related conditions to receive as		
 Counseling greater than 3 and up to 10 minutes 	a preventive service.		
Counseling greater than 10 minutes			
<u> </u>			
Subsequent annual wellness vîsit	At least 12 months since last AWV		

Physician's signature:	Date:

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