Physicians at Sugar Creek
An Affiliate of MEMORIAL HERMANN

14023 Southwest Freeway
Sugar Land, TX 77479
218.325.4100

Medicare Annual Wellness Visit Form

A WORD TO OUR PATIENTS ABOUT MEDICARE ANNUAL WELLNESS VISITS

Dear Patient,

We want you to receive wellness care – health care that may lower your risk of illness or injury. Medicare pays for some wellness care, but it does not pay for all the wellness care you might need. We want you to know about your Medicare benefits and how we can help you get the most from them.

The term "physical" is often used to describe wellness care. But Medicare does not pay for a traditional, head-to-toe physical. Medicare *does* pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:

- Screenings to detect depression, risk for falling and other problems
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity
- Recommendations for other wellness services and healthy lifestyle changes.

Before your appointment, our staff will ask you some questions about your health and will ask you to fill out a form.

A wellness visit does not deal with new or existing health problems. That would be a separate service and requires a longer appointment. **Please let our scheduling staff know if you need the doctor's help with a health problem, a medication refill or something else.** We may need to schedule a separate appointment. ***A separate charge applies to these services, whether provided on the same date or a different date than the wellness visit.***

We hope to help you get the most from your Medicare wellness benefits. Please contact us with any questions.

Sincerely,

Your health care team at Physicians at Sugar Creek

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Please complete the items below. If the question does not apply to you, please skip the item.

Please check "yes" or "no" for each of the following	**Yes**	**No**
Do you live alone? **If No, who lives with you?____________________**		
Does someone else help you take care of yourself? **If yes, is this person in good health?** _________________________		
Do you receive care from any home health company? **If yes, what is the company's name?** _________________________		
Does your home have fall risks like loose rugs, dim lights, etc.?		
Have you fallen in the past 6 months? **If yes, how many times?_____**		
Have you broken your back, spine, hip, or arm in the last year?		
Do you need an interpreter for visits to your doctor?		
Have you been in the hospital in the past year?		
What is your highest education level? **(circle one)** Middle School High School College Graduate School		
What is your preferred learning method? **(circle one)** Handouts/Reading Verbal Instructions		
Have you ever been abused? If Yes, circle what type? Sexual Abuse Domestic Abuse Elder Abuse		
Do you have leaking of urine?		
Do you get enough healthy food to eat?		
Are you having difficulties driving your car?		
Do you have trouble hearing?		
Do you have trouble seeing (more than just needing glasses)?		
Do you have smoke detectors in your house?		
Do you have carbon monoxide detectors in your house?		
Do you have safety bars in your bath or house?		
Do you have an emergency call device or button?		
Do you use any of the following? **(circle any that you use)** CANE CRUTCHES WALKER WHEELCHAIR SCOOTER		
Are you concerned about your memory?		

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Is your family concerned about your memory?		
Please check "yes" if you need help with any of the following (otherwise check "no")	**Yes**	**No**
Bathing?		
Dressing?		
Eating?		
Using the toilet?		
Getting out of bed or a chair?		
Travelling on buses, taxis, or in a car?		
Preparing your meals?		
Shopping for clothing or groceries?		
Housecleaning?		
Handling your own money (paying bills, etc.)?		
Taking your medications (remembering to take then or asking for refills)?		
Using the phone?		
Laundry?		

Please list names of any specialists you see:

Specialty	Name	For what problem? (i.e. heart failure)
Cardiology:		
GI:		
Neurologist:		
Eye Doctor:		
Urologist:		

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During the past 2 weeks, how often have you been bothered by any of the following problems?	**Never or rare**	**Some Days**	**More than ½ the days**	**Nearly every day**
Feeling nervous, anxious, or on edge				
Not being able to stop worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

If you checked off any problems, how difficult have these problems made it for you to do work, take care of things at home, or get along with other people?

Not difficult ____ Somewhat difficult____ Very difficult____ Extremely difficult____

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During the past 2 weeks, how often have you been bothered by any of the following problems?	Never or rare	Some Days	More than ½ the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping a lot				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, feeling like a failure, or that you let yourself or your family down.				
Trouble concentrating, like when you are reading or watching TV				
Moving or speaking so slowly that other people notice, or so fidgety and restless.				
Thinking you would be better off dead or that you want to hurt yourself in some way				

If you checked off any problems, how difficult have these problems made it for you to do work, take care of things at home, or get along with other people?

Not difficult ____ Somewhat difficult____ Very difficult____ Extremely difficult____

Do you have a durable power of attorney? Yes No

Do you have a living will (advanced directive)? Yes No

(If you answered "yes" to either item above, please make sure we have a copy)

Would you like information about either of these? Yes No

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Medications: (Please include name, dose, how many times a day, and why you take it)

Allergies: Please list all medications you are allergic to, and include what happens when you take it

Pharmacy: