Family Medical Group

Caring For Your Family

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A WORD TO OUR PATIENTS ABOUT MEDICARE AND WELLNESS CARE

Dear Patient:

Medicare covers an annual wellness visit at no cost to you. This visit is an opportunity for you and your healthcare provider to develop a personalized prevention plan that takes a comprehensive approach to improving your health and preventing disease. This means that you and your healthcare provider can develop a strategy together to help manage your health care.

This visit includes the following:

- **Routine measurements, such as your height, weight, blood pressure, and body mass index (BMI).**
- **Review of your individual medical and family history.**
- **Review of the medications, supplements, and vitamins that you are currently taking.**
- **Discussion of the care you are currently receiving from other healthcare providers.**
- **Review of your functional ability and level of safety (for example, your risk of falling at home), including any cognitive impairment, as well as a screening for depression.**
- **Discussion of personalized health advice that takes into account your risk factors and specific health conditions or needs, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.**
- **Discussion of referrals to other appropriate health education or preventive counseling services that may help you minimize or treat potential health risks.**
- **Planning a schedule for Medicare screening and preventive services.**

Although the annual wellness visit <u>is not the same as an annual physical exam</u>, it provides you with the same opportunity to talk with your healthcare practitioner about your health concerns.

After your initial annual wellness visit, you are eligible for a subsequent wellness visit every 12 months. The annual wellness visits are not subject to Medicare Part B deductibles, co-insurance, or copayments, which means that there is no expense to you. However, if during your visit your healthcare provider were to render services for any other condition (including medication refills) unrelated to the wellness visit, Medicare Part B deductibles, co-insurance, or copayments will apply.

We hope to help you get the most from your Medicare Wellness Benefits. Please contact our office with any questions you may have.

FAMILY MEDICAL GROUP, P.A.

Wellness Visit Patient Questionnaire

Annual Wellness Visit

Patient Name: ____ **Date:** _____________________________

Complete the Wellness Visit Patient Questionnaire and bring to your appointment.

SOCIAL HISTORY

Tobacco: ☐ Never ☐ Current Type: Frequency: ☐ 2nd Hand ☐ Prior Use Quit Date:

VAPE: ☐ Never ☐ Current Frequency: ☐ Prior Use Quit Date:

Alcohol: ☐ Never ☐ Occasional ☐ Daily **History of Alcohol:** (*describe*)

Caffeine: ☐ Never ☐ Occasional ☐ Daily (*how many cups*)

Drug Abuse: ☐ Never ☐ Occasional ☐ Daily ☐ Prior Use Quit Date:

History of Drug Abuse: (*describe*)

Exercise: ☐ Never ☐ Occasional ☐ Daily **Type of Exercise:**

Diet: ☐ Vegetarian ☐ Vegan ☐ Diabetic ☐ Low Salt ☐ Low Fat ☐ Low Carb ☐ Other (*describe*)

Is there a gun in the home? ☐ Yes ☐ No

Do you have a presence in social media? ☐ Yes ☐ No Site(s):
How often are you in social media? ☐ Daily ☐ Weekly ☐ Other

Do you have local family/friends support? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No **Contraceptive Method:** **Lifetime Partners: #**__________ **Years:**__________
Current sexual partners: ______________ ☐ Male ☐ Female ☐ Bisexual

Occupation: **Primary Language:**

SOCIAL HISTORY - ROUTINE TASKS

Please indicate if you DO or DO NOT need help performing these routine tasks

For all ☐ Yes answers specify who helps

TASKS	NO	YES	WHO HELPS
Getting from bed to chair			
Getting to the toilet			
Getting dressed			
Bathing or showering			
Walking across the room (including using a cane or walker)			
Using the telephone			
Taking your medicines			
Planning and preparing meals			
Managing money (like keeping track of expenses or paying bills)			
Moderately strenuous housework such as doing laundry			
Shopping for personal items like toiletries or medicines			
Shopping for groceries			
Driving			
Climbing a flight of stairs			

Wellness Visit Patient Questionnaire

Patient Name: ______________________________ **Date:** ____________________

FAMILY HISTORY Use √ to indicate positive history									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Alcoholism									
Breast Cancer									
Colon or Rectal Cancer									
Other Cancer									
Depression or Manic Depressive Disorder									
Diabetes									
Genetic Disorder									
Heart Disease									
Hypertension									
Kidney Disease									
Liver Disease									
Obesity									
Stroke									
Other *(specify)*									

MEDICAL HISTORY				
Hospital Visits Since Your Last Wellness Visit	Hospital Name	Attending Physician	Dates of Hospitalization	Past Surgeries, Dates, Reason and Any Complications

ALLERGY LIST	
Allergies	Type of Reaction

MEDICATION LIST					
Herbals, Supplements, Vitamins, Over The Counter Drugs, Substances of Abuse	Date Started	Date Discontinued	Prescribed Medications, Dose, Frequency, Route	Date Started	Date Discontinued

Wellness Visit Patient Questionnaire

Patient Name: ____ **Date:** ______________________________

OTHER PHYSICIANS AND PROVIDERS OF CARE		
Name & Specialty/Provider Type	**Type of Care**	**Date Discontinued**

HEALTH MAINTENANCE Record the last year you had the following. If you do not know, leave the date blank.			
VACCINES	**Date**	**EXAM**	**Date**
Hepatitis A		Dental Exam	
Hepatitis B		Depression Screening	
Influenza (flu)		Diabetes Screening	
Pneumococcal (pneumonia)		Diet Counseling	
Tetanus Shot		Domestic Violence Counseling	
Other Vaccines:		Eye Exam	
EXAM		Hepatitis B Screening	
Abdominal Aortic Aneurysm Screening		Hepatitis C Screening	
Alcohol Misuse Screening/Counseling		HIV Screening	
Blood Pressure Screening		HPV Screening	
Breast & Ovarian Cancer Screening (BRAC test)		Obesity Screening	
Cervical & Vaginal Cancer Screening (PAP)		Osteoporosis Screening	
Cholesterol Screening		Sexually Transmitted Infection Screening	
Colorectal Cancer Screening		Skin Cancer Screening	
Contraception Counseling		Tobacco Counseling	

FALL RISK	NO	YES
Have you fallen in the past year? (If yes, circle the circumstances surrounding the fall)		
• Tripped over something		
• Lightheadedness or palpitations prior to falling		
Loss of consciousness?		
Injured?		
Needed to see a doctor?		
Able to get up on your own?		

ADVANCED DIRECTIVE

Do you have an Advanced Directive (living will)? ☐ Yes ☐ No (*if* ***No,*** *are you able to prepare one?)*

Wellness Visit Patient Questionnaire

Patient Name: ____ **Date:** ______________________________

Patient questionnaire completed by patient? ☐ **Yes** ☐ **No** (*if no please indicate who assisted you*) ________________________________

Patient Signature ____ **Date** ______________________________

Nurse Initials:____________ **Date:**___________

Provider Signature (*to indicate review/notation of patient questionnaire*) ____**MD APRN**

FMG: 1/2020