Prime Healthcare Kansas City
Medicare Wellness Form

Patient Name:_____ DOB:_____ Date:_____

For Medicare to pay for a wellness visit and co-pay, you must only discuss wellness issues during the visit. If the Provider addresses other acute or chronic conditions during this appointment, additional charges **may** apply

PLEASE LIST: The names of ALL doctors you are currently seeing (last 2 years)

Provider Name	Specialty	Location	Comments
	Primary Care Provider	Oak Grove Medical Clinic	

CIRCLE THE ANSWER THAT APPLIES

Pain Assessment

Do you have any pain?	**YES**	**NO**	**N/A**
Where is your pain located?			
Please rate your pain on a scale of 0-10 (where 0 is no pain, and 10 is the worst)**0 1 2 3 4 5 6 7 8 9 10**			

Activities of Daily Living

Do you need assistance with grocery shopping, planning, and preparing?	**YES**	**NO**	**N/A**
Do you have trouble chewing, swallowing food, or have problems?	**YES**	**NO**	**N/A**
Do you need help with housework, i.e. dusting, washing dishes, vacuuming, etc?	**YES**	**NO**	**N/A**
Do you need help bathing or dressing?	**YES**	**NO**	**N/A**
Do you use any grab bars, rails or other assistive devices?	**YES**	**NO**	**N/A**

Functional Mobility Assessment

Do you use any of the following: Cane, Walker, Wheelchair?	**YES**	**NO**	**N/A**
Do you have any trouble getting in or out of the bathtub?	**YES**	**NO**	**N/A**
Do you have any trouble getting in or out of bed?	**YES**	**NO**	**N/A**
Do you have any trouble getting in or out of chairs?	**YES**	**NO**	**N/A**
Do you have any problems with making it to the bathroom on time?	**YES**	**NO**	**N/A**
Have you had any falls in the last 6 months?	**YES**	**NO**	**N/A**
Do you hold on to furniture, counters, or walls when you walk?	**YES**	**NO**	**N/A**
Do you have any oxygen tubing or urinary catheter?	**YES**	**NO**	**N/A**
Do you have a visual impairment?	**YES**	**NO**	**N/A**

Nutrition Assessment

Because of your health, have you had to change how you eat?	**YES**	**NO**	**N/A**
Do you eat fewer than 2 meals a day?	**YES**	**NO**	**N/A**
Do you eat few fruits, vegetables, or milk products?	**YES**	**NO**	**N/A**
Do you eat alone most of the time?	**YES**	**NO**	**N/A**
Have you lost or gained 10 pounds in the past 3 months without trying?	**YES**	**NO**	**N/A**
Do you ever have difficulty with shopping, cooking, and/or feeding yourself?	**YES**	**NO**	**N/A**

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Advance Directive

Do you have an Advance Directive?	**YES**	**NO**	**N/A**
Does your PCP have a copy of your Advance Directive?	**YES**	**NO**	**N/A**
Do you have a copy of your Advance Directive should you need to go to a hospital?	**YES**	**NO**	**N/A**
Do you wish to receive information/talk to your doctor about Advance Directives?	**YES**	**NO**	**N/A**

Psychosocial Assessment

Do you use alcohol?	**YES**	**NO**	**N/A**
How many drinks per day? _____ or per week_____			
Do you use tobacco?	**YES**	**NO**	**N/A**
If you are a smoker, would you like to quit?	**YES**	**NO**	**N/A**
Do you use street drugs and/or medications not prescribed for you?	**YES**	**NO**	**N/A**
Do you have any concerns about abuse or neglect?	**YES**	**NO**	**N/A**

Safety and Physical Activity

During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?					
Very Heavy	**Heavy**	**Moderate**	**Light**	**Very Light**	
Can you handle your own money without help?				**YES**	**NO**
During the past 4 weeks, how would you rate your health in general?					
Excellent	**Very Good**	**Good**	**Fair**	**Poor**	
Are you having difficulties driving your car?					
Yes - often	**Sometimes**	**No**	**N/A**		
Are you afraid of falling?				**YES**	**NO**
Do you exercise for about 20 minutes 3 or more days a week?					
Yes - most of the time	**Yes - some of the time**	**No - I do not usually exercise this much**			
How often in the past 4 weeks have you been bothered by any of the following problems:					
- Fall or dizzy when standing up?	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**
- Trouble eating well?	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**
- Teeth or dentures	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**
- Problems using the phone?	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**
- Tired or fatigued?	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**
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**

Hearing/Vision

Do you have any visual impairments or use visual aids such as glasses or contacts?	**YES**	**NO**	**N/A**
If so, which eyes?	**Right**	**Left**	**Both**
Last eye appointment was approximately _____Frequency of Eye Visits?_____			
Do you have a hearing impairment or wear hearing aids?	**YES**	**NO**	**N/A**
If so, which ears?	**Right**	**Left**	**Both**

PHQ-9 Depression Screening

In the last two weeks, have you felt little interest or pleasure in doing things?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
In the last two weeks, have you had feelings of being down, depressed, irritable, or hopeless?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Have you had trouble falling or staying asleep, or sleeping too much?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**

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PHQ-9 Depression Screening Cont'd

Have you been feeling tired or having little energy?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Have you had a poor appetite, weight loss, or overeating?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Have you been feeling bad about yourself – or that you are a failure and have let yourself or family down?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Trouble concentrating on things, such as reading the newspaper or watching television			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Moving or speaking slowly so that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Have thoughts that you would be better off dead, or of hurting yourself in some way?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**

Patient Signature:_____ Date: _____

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

For Provider Use Only:

Advanced Care Planning Discussed?	Y	N **Time Spent**:_____
Medications Reviewed?	Y	N
Problem List Reviewed?	Y	N
Surgical History Reviewed?	Y	N
Family History Reviewed?	Y	N
Aspirin/Opioid Use Reviewed?	Y	N
Depression Screen Administered?	Y	N**Time Spent**:_____
Fall Risk Screen Administered?	Y	N
Mini Cog Administered?	Y	N
Preventive recommendations discussed?	Y	N

Provider Signature:_____ Date: _____

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Preventive Measure (Copy of this given to patient)	Frequency Covered by Medicare	N/A	Date Done	Date Due
Bone Mass: *Post-menopausal females 65 years and older and those at increased risk (prolonged steroid use, FDA approved medications for osteoporosis, etc.).*	Every 2 years			
Colorectal Cancer Screening	****Patient's aged 50-75 years screening recommended; aged 76-85 years, consult PCP per USPSTF recommendations.**			
- *Colonoscopy*	Every 10 years (normal hx) Every 3-5 years (abnormal hx)			
- *Fecal Occult Blood Test (FOBT)* - *Cologuard*	Once a year (FOBT) Every 3 years (Cologuard)			
Glaucoma Screening: *(DM, Fam. Hx., African Am. 50+, Hisp. Am. 65+)*	Once a year			
Women's Health and Men's Health	****Women over 65 years may be able to discontinue screenings per recommended guidelines from ACS, USPSTF, and ACOG.**			
Cervical Cancer Screening w/ HPV ***All females Aged 30-65years***	Normal Risk: Once every 5 years High Risk: Once every year			
Screening PAP Test ***All females Aged 30-65years***	Normal Risk: Once every 2 years High Risk: Once every year			
Pelvic & Breast Exam ***All females***	Normal Risk: Once every 2 years High Risk: Once every year			
Mammogram ***All females Aged 40 and older***	Once a year			
Prostate Screening ***All males 50 and older***	Once a year			
Vaccine Series& Administration				
Influenza Virus Vaccine	Once a year			
Pneumococcal Vaccines *(for patients 65 years and older)*				
- *Prevnar-13 (PCV13)* **1 year apart from PPSV23**	Once a life-time			
- *Pneumovax-23 (PPSV23)* - **1 year apart from PCV13**	Once a life-time			
Hepatitis B Virus Vaccine	Series if increased risk (e.g. DM)			
Hepatitis C Virus Screening ***high risk patients, born between 1945-1965***	Once a life-time			
AAA Screening ***Male, Age 65-75, Hx smoking 100cig/lifetime*	Once a lifetime			
Low-Dose CT Lung Cancer Screening ***Age 50-80, current smoker or quit within 15 years, 20 pack/year hx, asymptomatic*	Once a year			

Diabetes:	For Patients with the Diagnosis of Diabetes Type 1 or Type 2			
A1C	>7.0%; every 3 months <7.0%; every 6 months			
Microalbumin – *urine*	Once a year			
Fasting Lipid Panel *(Must include Chol, LDL, HDL, Trig)*	Once a year; controlled Every 6 months; uncontrolled			
Diabetic Retinal Eye Exam	Once a year			
Foot Exam *Monofilament must be performed and doc.*	Once a year			