El Sol Family Medicine

_____	_____	□Female	_____
PRINT PATIENT NAME	PT DOB	□ Male	MRN

Dear Patient:

You are scheduled today for your Medicare Annual Wellness visit.

Please know that Medicare limits reimbursement for this service to once every 365 days. If you have received this service from another provider within the past 365 days you may be charged for this visit.

The Medicare Annual visit includes the following:

- Health Risk Assessment (HRA) or update.
- Medical Family History or update.
- List of current providers and suppliers.
- Weight, blood pressure and other routine measurements deemed needed by the provider.
- Cognitive assessment.
- General health status and risk factor screenings.
- Referrals for prevention and education as needed.
- For more information on Medicare Annual Wellness visits please go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

The Medicare Annual Wellness visit does not include the services below. If you require these additional services today, please be aware Medicare has a separate billing category for which your provider may charge Medicare. Alternatively, please let your provider know if you do not want these services.

- Evaluation and Management of new or ongoing problems requiring further workup or discussion. This may include a more extensive problem focused physical exam, ordering of diagnostic tests for known problems, prescription drug management, coordinating care with another specialist, or simply providing further counseling related to a chronic diagnosis.
- A more comprehensive Preventative Physical exam than what is included in the Medicare Annual Wellness visit.

If you have any questions regarding this information, please see the front desk staff.

I have received and read this information.

_____	_____
PATIENT SIGNATURE	DATE

El Sol Family Medicine

_____ _____ □Female _____
PRINT PATIENT NAME PT DOB □ Male MRN

Medicare Annual: [ ] Initial AWV G0438 [ ] Subsequent AWV G0439 [ ] Welcome to Medicare G0402

MEDICARE HEALTH RISK ASSESSMENT (HRA)

A requirement of Medicare is to complete this form prior to seeing your medical provider for your wellness exam**.**
Please fill out or circle the information that applies to you.

LIST OF OTHER PHYSICIANS / PROVIDERS: (*Examples: Rheumatology, Gastro, Dermatology, Endocrinology, ENT, Neurology, Oncology, Ophthalmology, Orthopedic, Pain Mgmt., PT, Podiatry, Pulmonary, Radiology or GYN)*

_____

_____

_____

PLEASE CIRCLE YOUR RESPONSE TO THE FOLLOWING QUESTIONS

Can you prepare your own meals?	**Yes**	**No**
Can you do housework without help?	**Yes**	**No**
Can you handle money without help?	**Yes**	**No**
Do you exercise for about 20 minutes 3 or more times a week?	**Yes**	**No**
Can you go shopping for groceries or clothes without someone's help	**Yes**	**No**
Can you get to places out of walking distance without help (e.g., travel alone by bus or car)	**Yes**	**No**
Is someone able to help you if needed	**Yes**	**No**
Are you afraid of falling?	**Yes**	**No**
Have you fallen 2 or more times in the past year	**Yes**	**No**
Because of health problems, do you need another person to help with bathing, eating, etc.?	**Yes**	**No**

Do you have any limitations in: dressing, bathing, toileting, transferring, feeding or incontinence? **Yes** **No**

If yes, please explain: _____

How would you rate you hearing loss? **Does not Apply** **Mild** **Moderate** **Severe**

How would you rate your home safety (e.g. smoke alarms, stairs, CO2 monitors)?

Good **Fair** **Needs Improvement**

Are you having difficulties driving your car? **Yes** **Sometimes** **No** **I Don't Drive**

Do you fasten your seatbelt when in a car? **Yes** **Sometimes** **No**

Do you have trouble taking medications? **Yes** **Sometimes** **No**

How confident are you that you can control and manage most of your health problems?

Very **Somewhat** **Unsure**

COGNITIVE IMPAIRMENT:

Short Term Memory Recall: **Good** **Mild** **Moderate** **Severe**

Long Term Memory Recall: **Good** **Mild** **Moderate** **Severe**

PLEASE ANSWER THE BELOW QUESTIONS IN REGARDS TO THE **PAST MONTH ONLY.**

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_____	_____		_____

How you rate your health in general **Excellent Good Fair Poor**

How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue? **None Mild Moderate Severe**

How much have you been bothered by a lack of interest or pleasure in doing things?

None Mild Moderate Severe

Has your physical and emotional health limited your social activities with family friends, neighbors or groups?

None Mild Moderate Severe

How much bodily pain have you generally had? **None Mild Moderate Severe**

What was the hardest physical activity you could do for at least 2 minutes? **Heavy Moderate Light**

Are you a smoker? **Yes, might quit Yes, won't quit No**

During the past week, how many alcohol drinks did you have?

More than 15 7-15/week Less than 7/week None

HAVE YOU HAD PROBLEMS WITH ANY OF THE BELOW? *PLEASE CIRCLE ALL APPROPRIATE ITEMS.*

Dizzy or falling when standing	Sexual problems
Trouble eating well	Teeth or denture problems
Problems using the telephone	Tiredness or fatigue

DO YOU NEED ANY INFORMATION ON THE FOLLOWING? *PLEASE CIRCLE ALL APPROPRIATE ITEMS.*

Fall Prevention Nutrition Physical Activity Tobacco-use Cessation Weight Loss

ADVANCED DIRECTIVES:

Do you have an advanced directive? (Living wills, etc.) **Yes No**

Who has copies of them? _____

Do you have the ability to prepare Advanced Directives, if you haven't already? **Yes No**

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Scan under "Medicare Health Assessment"

El Sol Family Medicine

_____ _____ □Female _____

PRINT PATIENT NAME PT DOB □ Male MRN

1. During the past 2 weeks, have you often been bothered by feeling down, depressed, or hopeless?
   ❑ Yes ❑ No
2. During the past 2 weeks, have you often been bothered by little interest or pleasure in doing things?
   ❑ Yes ❑ No

Patient Health Questionnaire (PHQ-9)

If you have answered yes to any of the questions above please continue if not STOP

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure of have let yourself or your family down.	0	1	2	3
7. Trouble Concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly 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	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
10. How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Add columns _____ + _____ + _____

TOTAL: _____

Patient Signature: _____ Date_____

Provider Signature: _____ Date _____

Scan under "Health Assessment Tools > PHQ 9"

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Hearing Assessment Questionnaire

The onset of hearing loss is usually very gradual. It may take place over 25-30 years or it may happen more rapidly if you are exposed to loud noises at work or through hobbies. Because it usually occurs slowly, you may not even be aware you have a problem until someone else brings it to your attention. Here is a simple test you can take to determine if you have a hearing problem. Please circle the most appropriate answer to each question.

1. Do you ever experience feelings of dizziness? Yes or No
2. Do you have ringing or other noises (tinnitus) in your ears? Yes or No
3. Do others complain that you watch television with the volume too high? Yes or No
4. Do you frequently have to ask others to repeat themselves? Yes or No
5. Do you have difficulty understanding when in groups or in noisy situations? Yes or No
6. Do you have to sit up front in meetings or in church in order to understand? Yes or No
7. Do you have difficulty understanding women or young children? Yes or No
8. Do you have trouble knowing where sounds are coming from? Yes or No
9. Are you unable to understand when someone talks to you from another room? Yes or No
10. Have others told you that you don't seem to hear them? Yes or No
11. Do you avoid family meetings or social situations because you "can't understand? Yes or No

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Scan under "Medicare Health Assessment"