



PRINT PATIENT NAME

PT DOB

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

JRA

Site Name



Female
 Male

PRINT PATIENT NAME _____ PT DOB _____

MRN _____

Patient Health Questionnaire (PHQ)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Please circle your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
2. Feeling tired or having little energy	0	1	2	3
3. Poor appetite or overeating	0	1	2	3
4. Feeling bad about yourself- or that you are a failure of have let yourself or your family down.	0	1	2	3
5. Trouble Concentrating on things, such as reading the newspaper or watching television	0	1	2	3
6. 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
7. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
8. 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 column: _____ + _____ + _____

TOTAL: _____

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these 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 _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

El Sol Family Medicine

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Female

Male

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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 check or fill out the information that applies to you.

1. Have you been hospitalized since we last saw you?
 Yes If yes: Where? When: _____
 No
2. Have you seen a health care provider outside our clinic since we last saw you?
 Yes If yes: Where? When: _____
 No
3. Over the last 2 weeks, how often have you been bothered by any of the following problems?
Little interest in doing things
 Not at all
 Several days
 More than half the days
 Nearly every day
Feeling down, depressed, or hopeless
 Not at all
 Several days
 More than half the days
 Nearly every day
4. In general, how would you say your health is?
 Excellent
 Good
 Fair
 Poor
5. In general, how satisfied are you with your life?
 Very Satisfied
 Satisfied
 Dissatisfied
 Very Dissatisfied
6. In the past 7 days, how much pain have you felt?
 None A lot
 Some
7. Do you usually exercise at least 30 minutes or more, 4 days a week?
 Yes
 No
8. Do you usually eat a diet that has at least 4 servings of fruit & vegetables, includes whole grain & fiber and avoids other than occasional servings of high fat foods?
 Yes
 No
9. How would you describe the condition of your mouth and teeth (including false teeth or dentures)?
 Excellent
 Good
 Poor
10. How often do you have a drink containing alcohol?
 Never
 Monthly or less
 2—4 times a month
 2-3 times a week
 4 or more times a week
 Patient refused
11. How often do you have six or more drinks on one occasion?
 Never
 Less than monthly
 Monthly
 Weekly
 Daily or almost daily
 Patient refused
12. Do you always fasten your seat belt when you are in the car?
 Yes
 No

El Sol Family Medicine

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Male

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13. Do you know where to locate and how to properly use a first aid kit and fire extinguisher in case of an emergency?

- Yes
- No

14. In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

- Yes
- No

15. Do you have problems with bladder control or urinary leakage?

- None
- Sometimes
- Always

16. In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

- Yes
- No

17. In the past 7 days have you had any problems staying or falling asleep?

- Yes
- No

18. Have you fallen in the last year?

- 2 or more falls in the last year or fall with injury in the last year
- No falls in the last year or 1 fall with no injury in the last year

19. Do you have problems with your balance?

- None
- Sometimes
- Always

20. Does your home have any of the following possible safety concerns or issues?

- Loose rugs Yes No
- Handrails on stairs Yes No
- Grab bars in bathroom Yes No

21. Does your home have good lighting?

- Yes
- No

22. Do you or any of your friends or family members have any concerns about your memory?

- Yes
- No

23. Do you have any problems with your hearing?

- Yes
- No

LIST OF OTHER PHYSICIANS / PROVIDERS:

(Examples: Rheumatology, Gastro, Dermatology, Endocrinology, ENT, Neurology, Oncology, Ophthalmology, Orthopedic, Pain Mgmt., PT, Podiatry, Pulmonary, Radiology or GYN)

ADVANCED DIRECTIVES (living wills, etc.)

Do you have the ability to prepare advanced directive if you haven't already?

- No
- Yes

Do you have an advanced directive?

- No
- Yes - Who has copies of them? _____

SITE NAME

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Male


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SOCIAL QUESTIONNAIRE

These are questions about you and your family situation that may affect your health. It is also possible we may be able to use your answers to connect you with services available to you. Please check all correct response(s) for each question.

1. On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?
 0 days 1 day 2 days 3 days
 4 days 5 days 6 days 7 days
 Patient refused
2. On average, how many minutes do you engage in exercise at this level?
 0 min 10 min 20 min 30min 40min
 50min 60min 70min 80min 90 min
 100min 110min 120min 130min
 140min 150+min Patient refused
3. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
 Not hard at all Hard
 Not very hard Very hard
 Somewhat hard Patient refused
4. In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time?
 Yes No Patient refused
5. In the last 12 months, how many places have you lived? _____
6. In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now) ?
 Yes No Patient refused
7. In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?
 Yes No Patient refused
8. In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?
 Yes No Patient refused
9. Within the past 12 months, you worried that your food would run out before you got the money to buy more?
 Never true Sometimes true
 Often true Patient refused
10. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more?
 Never true Sometimes true
 Often true Patient refused
11. Do you feel stress – tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time – these days?
 Not at all Only a little
 To some extent Rather much
 Very much Patient refused
12. In a typical week, how many times do you talk on the phone with family, friends, or neighbors?
 Never Once a week
 Twice a week Three times a week
 More than three times a week
 Patient refused
13. How often do you get together with friends or relatives?
 Never Once a week
 Twice a week Three times a week
 More than three times a week
 Patient refused
14. Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?
 Yes No Patient refused
15. How often do you attend meetings of the clubs or organizations you belong to?
 Never 1 to 4 times per year
 More than 4 times per year
 Patient refused
16. Are you married, widowed, divorced, separated, never married, or living with a partner?
 Married Widowed Divorced Separated
 Never married Living with Partner
 Patient refused

Continued on next page 

02/28/2023

SITE NAME

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Female

Male

DATE

MRN

SOCIAL QUESTIONNAIRE

These are questions about you and your family situation that may affect your health. It is also possible we may be able to use your answers to connect you with services available to you. Please check all correct response(s) for each question.

17. Within the last year, have you been afraid of your partner or ex-partner?

Yes No Patient refused

18. How often do you have a drink containing alcohol?

Never Monthly or less
 2-4 times a month 2-3 times a week
 4 or more times a week
 Patient refused

19. How many drinks containing alcohol do you have on a typical day when you are drinking?

Patient does not drink 1 or 2
 3 or 4 5 or 6 7 to 9
 10 or more Patient refused

20. How often do you have six or more drinks on one occasion?

Never Less than monthly
 Monthly Weekly
 Daily or almost daily Patient refused

02/28/2023

Arizona Community Physicians, P.C.
Adult
Release of Information Form

Account # _____

Patient Name _____ DOB _____ Date _____

Guardian Name _____ Contact Number: _____

The confidentiality of our patient's medical information is very important to us. We understand there may be circumstances in which a family member or other adult needs access to your health information.

Please list the names and phone numbers of anyone who has your permission to have access to your medical records. This information is not limited to but includes appointments, billing information and test results.

Name/relationship _____ Contact Number _____

Name/relationship _____ Contact Number _____

Name/relationship _____ Contact Number _____

By providing the below phone #(s) you are giving permission, to leave appointment information or detailed information regarding, lab results, radiological results or any other imperative information on the phone # indicated below

Cell/Mobile voice mail _____ (Phone #)

Home voice mail _____ (Phone #)

DO NOT RELEASE Information to the following people: _____

I acknowledge that either I or the physician may, at any time, withdraw the option of releasing test information per the terms of this agreement, upon providing written notice. Any questions I had have been answered.

Name Patient/Guardian: _____ Signature _____ Date _____

The information provided on this form will stay in effect until updated by the patient