ANTHEM MEDICAL CENTER
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MEDICARE WELLNESS VISIT (☐ W ☐ F ☐ S)

Patient's Name_____Date of Birth: ___/____/___

Medicare B eligibility date: _____ Today's Date: _____ Date of last exam: _____

Other Insurance Plan: _____

Please list any changes to Name, Address, Marital status, E-mail, Phone number, Emergency contact:

What is the best way to communicate with you?
English ☐Yes ☐ No Other Language:_____ Other Method: _____

FUNCTIONAL STATUS ASSESSMENT:

In general, would you say your	Excellent	Good	Fair	Poor	Other
Walking ability is	☐	☐	☐	☐	☐ Use wheelchair ☐ Use Walker/cane ☐ Amputation
Hearing is	☐	☐	☐	☐	☐ Deaf ☐ Use hearing aids
Vision is	☐	☐	☐	☐	☐ Use glasses/contacts ☐ Blind ☐ Cataract ☐ Glaucoma ☐ Macular Degeneration
Speech is	☐	☐	☐	☐	

PSYCHOSOCIAL & BEHAVIORAL RISKS:

In general, would you say your health is
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

How often do you get the social and emotional support you need?
☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

How would you rate the mechanism in place for getting help when you need assistance with something?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

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

Are you the primary caregiver for someone with chronic medical illness: ☐ Yes ☐ No

PAIN ASSESSMENT

Are you experiencing any pain? ☐ Yes ☐ No Please rate you pain on a scale of 1-10 _____	Description/Location: _____
Please list any medication you take to manage your pain:	

How often during <u>the past 4 weeks</u> have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or feel dizzy when standing up	☐	☐	☐	☐	☐
Sexual Problems	☐	☐	☐	☐	☐
Trouble eating well	☐	☐	☐	☐	☐
Teeth or dentures	☐	☐	☐	☐	☐
Problems using the telephone	☐	☐	☐	☐	☐
Tired or fatigued	☐	☐	☐	☐	☐
Difficulty driving your car	☐	☐	☐	☐	☐
Depression and sadness	☐	☐	☐	☐	☐
Anger and irritability	☐	☐	☐	☐	☐
Anxiety and worry	☐	☐	☐	☐	☐
Isolation and loneliness	☐	☐	☐	☐	☐

Do you always fasten your seat belt when you are in a car: ☐ Yes, always ☐ Yes, Usually ☐ No

***Tobacco Use*: Have you **ever smoked**? ☐ Never ☐ **Yes**

If yes, do you **currently smoke** - ☐ No ☐ **Yes** and I might quit ☐ **Yes**, but I am not ready to quit yet
If yes, do you smoke ☐ **every day or** ☐ **some days** only
What form of tobacco do you use? ☐ Cigarettes ☐ Pipe ☐ E-Cig/Vape ☐ Cigar? ☐ Snuff ☐ Chew.
How much do you smoke? ____ /day.
If **Former smoker**, Quit Date/Year _____. For how many years did you smoke? ____ years.
How many cigarettes did you use to smoke in the past? ☐ 1 pack per day (PPD) ☐ 1/2 PPD ☐ 1/4 PPD or less

***Alcohol Use**:* Do you sometimes drink beer, wine, or other alcoholic beverages? ☐ No ☐**Yes**

If yes, *how often* do you have a drink containing alcohol?
☐ Once a month or less often ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

How many standard drinks containing alcohol do your have on a typical day:
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have *six or more* drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Intravenous/Addictive/Street Drug Use: ☐ No ☐ Yes - which drug? _____ Current user ☐ Yes ☐ No
Last used? _____. Mode of Use? ☐ By Mouth☐ By Injection ☐ Through Nose ☐ Other_____

ACTIVITIES OF DAILY LIVING:

Are you able to do the following independently or need assistance from others:

- Bathing ☐ Independent ☐ With assistance from others
- Dressing ☐ Independent ☐ With assistance from others
- Grooming ☐ Independent ☐ With assistance from others
- Toileting ☐ Independent ☐ With assistance from others
- Feeding ☐ Independent ☐ With assistance from others
- Transferring ☐ Independent ☐ With assistance from others

Do you have control of your bladder? ☐ Full control ☐ Small leaks ☐ No control
Do you have control of your bowels? ☐ Full control ☐ No control

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

During the <u>past 4 weeks</u>, have you had any trouble doing any of the following?

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Managing Medications	☐ No difficulty	☐ Yes, sometimes	☐ Yes, Require assistance from others
Getting around the home	☐ No difficulty	☐ Yes, sometimes	☐ Yes, Require assistance from others
Doing Laundry	☐ No difficulty	☐ Yes, sometimes	☐ Yes, Require assistance from others
Using the Telephone	☐ No difficulty	☐ Yes, sometimes	☐ Yes, Require assistance from others
Traveling	☐ No difficulty	☐ Yes, sometimes	☐ Yes, Require assistance from others
Grocery Shopping	☐ No difficulty	☐ Yes, sometimes	☐ Yes, Require assistance from others
Preparing Meals	☐ No difficulty	☐ Yes, sometimes	☐ Yes, Require assistance from others
Managing Money	☐ No difficulty	☐ Yes, sometimes	☐ Yes, Require assistance from others
Getting around the home	☐ No difficulty	☐ Yes, sometimes	☐ Yes, Require assistance from others
Housekeeping	☐ No difficulty	☐ Yes, sometimes	☐ Yes, Require assistance from others

Please list any changes to your MEDICAL HISTORY in the past year:

_____

_____

_____

Please list any changes to your FAMILY HISTORY in the past year:

_____

Please list any changes to SURGICAL/HOSPITALIZATION HISTORY in the past year:

_____

_____

Any Injuries in the past year:

_____

ALLERGIES TO MEDICATIONS: ☐ None, *or* please list Medication and the type of reaction to it:

_____

☐ Skin Rash ☐ Lip &Tongue Swelling ☐ Anaphylactic Shock ☐ Other_____

MEDICATIONS: Please list all your medications – ***prescription, over the counter, Vitamins and Herbs***:

1.	**6.**	**11.**
2.	**7.**	**12.**
3.	**8.**	**13.**
4.	**9.**	**14.**
5.	**10.**	**15.**

Current Providers and Suppliers:

Please provide information about your preferred pharmacy.

Retail Pharmacy _____ Address _____

Mail Order Pharmacy: _____

Please provide information about your Durable Medical Equipment Suppliers:

Supplier Name _____ Address _____

Equipment supplied: ☐ Oxygen ☐ CPAP ☐ BiPAP ☐ Diabetes Supplies ☐ Wheel Chair
☐ Motorized Wheel chair ☐ Scooter ☐ Brace ☐ Other _____

Who is/are your Current Doctors:

Doctor's Name _____ Address _____

Phone _____ Fax _____Specialty: _____

Doctor's Name _____ Address _____

Phone _____ Fax _____Specialty: _____

Doctor's Name _____ Address _____

Phone _____ Fax _____Specialty: _____

Doctor's Name _____ Address _____

Phone _____ Fax _____Specialty: _____

DEPRESSION SCREEN:

Over the last two weeks, how often have you been bothered by any of the following problems:

	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 or 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. Though that you would better off dead, or of hurting yourself	0	1	2	3
Add columns				

Total: _____

10. How difficult have these 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 _____

Screening for potential Substance Use Disorders (SUDs):

In the past year, how often have you used the following?

Alcohol (for men, 5 or more drinks a day. For women, 4 or more drinks a day)
☐ Never ☐ Once or Twice ☐ Weekly ☐ Monthly ☐ Daily or Almost Daily

Tobacco Products
☐ Never ☐ Once or Twice ☐ Weekly ☐ Monthly ☐ Daily or Almost Daily

Prescription Drugs for Non-Medical Reasons
☐ Never ☐ Once or Twice ☐ Weekly ☐ Monthly ☐ Daily or Almost Daily

Illegal Drugs
☐ Never ☐ Once or Twice ☐ Weekly ☐ Monthly ☐ Daily or Almost Daily

DIET:

Number of Meals/Day		☐ 1	☐ 2	☐ 3	☐ Other _____
Number of Snacks/Day	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____
Fast food/Week	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____
What is your daily consumption of :	**Number of Servings**				
Meat/Fish/Chicken	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____
Dairy	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____
Eggs	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____
Sweats/Desserts	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____
Soft Drinks	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____
Fruits	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____
Vegetables	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____
Whole Grains	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____
Legumes (Beans & Lentils)	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____
Nuts & Seeds	☐ None	☐ 1	☐ 2	☐ 3	☐ Other _____

EXERCISE: Do you exercise regularly? ☐ No ☐ Yes - What type? ☐ Aerobic ☐ Stretching ☐ Weight Lifting
How Long?_____ ☐ Minutes/Day ☐ Hours/Day How Often? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week

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HEARING EVALUATION: Do you think you may have a hearing loss? ☐ Yes ☐ No.
If yes, do you use a hearing aid? ☐ Yes ☐ No

Fall Risk Screening:
Have you fallen 2 or more times in the past 12 months or had a fall with injury? ☐ No ☐ Yes
Are you having trouble with walking or balance? ☐ No ☐ Yes

Advance Care Planning: ***Have you prepared the following documents?***

Advance Directives (in case of an illness or injury preventing you from making decisions): ☐Yes ☐No

Power of Attorney for Healthcare: ☐Yes ☐No

Physician Orders for Life Sustaining Treatment **(POLST) [**only for people with terminal illness**]**: ☐Yes ☐No

If you have not prepared these documents do you need help in preparing these? ☐ Yes ☐ No