Family Health Center of Sierra Vista
1800 E Wilcox Dr
Sierra Vista, AZ 85635
520-459-3116

Date:_____
Appointment date: _____

Dear _____,

Please take the time to answer these **IMPORTANT** questions:

***Have you had a Medicare Annual Wellness Visit (AWV) or Physical with another medical practice within the last 12 months? __YES __NO If YES, If it was done within the last 12 months of this scheduled visit, please call our office to reschedule otherwise you may be financially responsible for this visit. Medicare only allows one AWV within a 12 month period.
***Have you received a phone call from your insurance company asking you questions similar to the ones in this questionnaire within the last 12 months? ___YES ___NO If YES, Please contact our office PRIOR to your scheduled visit so we can verify if they have already billed for an AWV otherwise you may be financially responsible for this visit

Thank you for scheduling your **Medicare Annual Wellness Visit**. You may know already that Medicare has developed a new health care visit for its beneficiaries called an "Annual Wellness Visit". There is no co-pay or coinsurance for this service, as it is paid 100% by your Medicare plan. It is important to know, however, that there may be fees associated with studies ordered during this visit .

The goal of this visit is to provide time for you to focus on areas of your health that put you at risk for problems in the future. As part of the visit, you will be screened for fall risk, safety risk, worsening memory, hearing, depression and other medical concerns. *This Annual Wellness Visit* ***does not include a thorough physical exam or discussion of your chronic health problems.*** If additional health problems are addressed during this visit, *a co-pay or coinsurance may be required for that portion of the visit.*

In order to help the visit run smoothly, please **bring all your medicine bottles** and complete the enclosed forms and bring them with you to your visit**. If you arrive at the clinic without these forms, your Annual Wellness Visit may have to be rescheduled. You will however, be allowed to see the provider regarding your other health issues. A co-pay or coinsurance may be required for this visit.**

When you arrive at the clinic, please tell the staff that you are here for your **Medicare Annual Wellness Visit and hand them these completed forms**. We look forward to seeing you for your visit.

Please call us if you have any questions at 520-459-3116.

Sincerely,

Family Health Center of Sierra Visita

NAME_____ DOB_____ DATE OF SERVICE_____

Please provide a complete list of the following items:

- List of the doctors and specialists that you have seen, Write their name next to their specialty:

  Cardiologist_____ Nephrologists_____

  Dermatologist_____ Oncologist_____

  Gastroenterologist_____ Ophthalmologist_____

  Endocrinologist _____ Orthopedist_____

  Pulmonologist_____ Urologist_____

  Other: _____ Other:_____

- List of your medications and supplements, including doses:

  _____ _____

  _____ _____

  _____ _____

  _____ _____

  _____ _____

  _____ _____

  _____ _____

  _____ _____

  _____ _____

- LIST YOUR MEDICAL PROBLEMS LIST YOUR SURGERIES with DATES

  _____ _____Date_____

  _____ _____Date_____

  _____ _____Date_____

  _____ _____Date_____

  _____ _____Date_____

  _____ _____Date_____

Tell us what HEALTH problems your parents, siblings, and children have or have had in the past:

Parents:	Mother- Father-
Siblings:	Brother(s): Sister(s):
Children:	Son(s) Daughter(s):

Reviewed by:_____ **Date**_____

NAME_____ **DOB**_____ **Date of Service:** _____

Medicare Annual Wellness Health Risk Assessment (HRA) (rev 8/11/17)

1 During the **past 4 weeks**, how much bodily pain have you generally had?
__No pain
__ Very mild pain
__ Moderate pain
__ Severe pain

On a scale from 1-10 with 10 being the greatest pain, please rate your level of pain.
Mild - 1 2 3 4 5 6 7 8 9 10 – Greatest

2 During the **past 4 weeks**, *was someone available to help you* if you needed and wanted help? For example, if you felt very nervous, lonely, or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.
__ Yes, as much as I wanted
__ Yes, quite a bit
__ Yes, some
__ Yes, a little
__ No, not at all

GENERAL HEALTH

3. During the **past 4 weeks**, how would you rate your health in general?
__ Excellent
__ Very good
__ Good
__ Fair
__ Poor

4. How have things been going for you during the **past 4 weeks?**
__ Very well- could hardly be better
__ Pretty good
__ Good and bad parts about equal
__ Pretty good
__ Very bad- could hardly be worse

5. Are you having difficulties driving your car?
__ Yes, often
__ Sometimes
__ No
__ Not applicable, I do not use a car

6. Do you always fasten your seat belt when you are in a car?
__ Yes, usually __ Yes, sometimes __ No

7. How often during the **past 4 weeks** have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up					
Trouble eating well					
Teeth or dentures					
Problems using the telephone					
Tired or fatigued					

PHYSICAL ACTIVITY

8. During the **past 4 weeks**, what was the hardest physical activity you could do for at least 2 minutes?
___ Very heavy (like fast running or stair climbing)
___ Heavy (like jogging or swimming)
___ Moderate (like brisk walking)
___ Light (like stretching or slow walking)
___ Currently not exercising

9. 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 usually do not exercise this much.

ACTIVITIES OF DAILY LIVING	YES	NO
1. Can you prepare your own meals?		
2. Can you do your own housework without help?		
3. Can you handle your own money or finances without help?		
4. Do you need help eating, bathing, toileting or getting around your home?		
5. Do you need assistance with activities such as grooming or dressing?		

NAME_____

DOB_____ **DATE OF SERVICE**_____

TOBACCO USE

10. Are you a smoker?
    - ___ No
    - ___ Yes, and I might quit
    - ___ Yes, but I'm not ready to quit
    - ___ Use Smokeless tobacco
    - ___ E-Cigarettes
    - ___ recreational or medical marijuana
    - ___ If yes, How many packs a day _____

11. **HOME SAFETY**

	YES	NO
Do you live alone?		
Do you have throw rugs in the home?		
Does your home have poor lighting?		
Do you have a slippery bathtub or shower?		
Do you have functional smoke alarms?		
Do you have grab bars in the bathroom?		
Do all stairs and steps have railing?		
Are doorways, halls and stairs free of clutter?		
Is there any family violence or spousal abuse in your home?		

ALCOHOL USE

12. During the **past 4 weeks**, how many drinks of ___wine,___ beer or ___other_____ Alcoholic beverages did you have?
    - ___ 10 or more per week
    - ___ 6-9 per week
    - ___ 2-5 per week
    - ___ 1 drink or less per week
    - ___ No alcohol at all

13. How often do you have trouble taking medicines the way you have been told to take them?
    - ___ I do not have to take medicine
    - ___ I always take them as prescribed
    - ___ Sometimes I take them as prescribed
    - ___ I seldom take them as prescribed

NUTRITION

14. I eat at least 5 servings of fruits and vegetables every day (one serving equals ½ cup)
    ___Yes ___No

15. I avoid eating foods that are high in fat such as whole milk, fried foods, fatty meats, etc
    ___Yes ___ No

16. I maintain a healthy weight within the recommendations specified by a health care professional.
    _____Yes ___ No

COGNITIVE IMPAIRMENT SCREENING

	YES	NO
1. Do you have difficulty finding your way home or knowing where you live?	O	O
2. Do you have difficulty recognizing familiar faces**?**	O	O
3. Do you have difficulty remembering the current date?	O	O

ADVANCED CARE PLANNING:

Do you have a Living Will? ___Yes ___No ___I don't know.
Do you have a Durable Power of Attorney? ___Yes ___No ___I don't k now
Do you want to discuss obtaining an Advanced Directive with the provider? ___Yes ___No

Reviewed by:_____ Date_____

Name_____ **DOB**_____ **DOS**_____

DEPRESSION SCREEN

1 During the **past 4 weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
__Not at all __Slightly __ Moderately __Quite a bit __ Extremely

2 During the **past 4 weeks** has your physical and emotional health limited your social activities with family and friends, neighbors, or groups?
__ Not at all __Slightly __ Moderately __Quite a bit __ Extremely

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following:	(0) Not at all	(1 pt) Several days	(2 pts) More than half the days	(3 pts) Nearly every day
Little interest or pleasure in doing things?	O	O	O	O
Feeling down, depressed, or hopeless?	O	O	O	O
Trouble falling or staying asleep, or sleeping too much?	O	O	O	O
Feeling tired or having little energy?	O	O	O	O
Poor appetite or overeating?	O	O	O	O
Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	O	O	O	O
Trouble concentrating on things, such as reading the newspaper or watching television?	O	O	O	O
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 that usual?	O	O	O	O
Thoughts that you would be better off dead or of hurting yourself in some way?	O	O	O	O
SCORE	_____	_____	_____	_____

Item **HEARING SCREENING**	(4) Yes	(2) Sometimes	(0) No
Does a hearing problem cause you to feel embarrassed when you meet new people?	O	O	O
Does a hearing problem cause you to feel frustrated when talking to members of your family?	O	O	O
Do you have difficulty hearing when someone speaks in a whisper?	O	O	O
Do you feel handicapped by a hearing problem?	O	O	O
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	O	O	O
Does a hearing problem cause you to attend religious services less often than you would like?	O	O	O
Does a hearing problem cause you to have arguments with family members?	O	O	O
Does a hearing problem cause you difficulty when listening to TV or radio?	O	O	O
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	O	O	O
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	O	O	O
SCORE	___	___	___

Reviewed by_____ Date_____

NAME_____ DOB_____ DATE OF SERVICE_____

Fall Risk Assessment

The purpose of this questionnaire is to determine if you are experiencing dizziness or unsteadiness due to a recent injury or medical condition. Please answer the following questions as it pertains to your dizziness or unsteadiness only.	**YES**	**NO**
1 Did you ever fall or think you were about to fall?	O	O
2 Are you dizzy or unsteady when you first get up?	O	O
3 Do you worry that you may fall or hurt yourself?	O	O
4 Does moving your head quickly make you dizzy?	O	O
5 Does bending over make you dizzy?	O	O
6 Does your dizziness or imbalance problem interfere with your job or household duties?	O	O
7. Have you fallen 2 or more times in the past year?	O	O
8.Are you afraid of falling?	O	O
9 Do you avoid outdoors for fear of falling?	O	O

Additional Screening Studies:

To the best of your recollection, have you had any of the following studies done within the 12 months?	**Yes**	**No**	**I Don't Know**
Have you had a colonoscopy? (age 50 and over) If yes, Date_____ Doctor's name_____	O	O	O
Have you had an abdominal aortic aneurysm ultrasound? If yes, year_____ where(Facility)_____?	O	O	O
Prostate Cancer screening? (age 50 and over) If yes, when_____ History of prostate cancer? __Yes __No	O	O	O
Diabetes screening? If yes, when was your last test?_____ Have you previously been diagnosed with Diabetes? ___Yes __No	O	O	O
Glaucoma screening (your last eye exam) ? If yes, when _____ by whom? (Doctor's name)_____?	O	O	O
Lipid screening? If yes, when was your last test?_____	O	O	O
Have you had flu vaccine within the last 12 months? If yes, when _____and where _____	O	O	O
Have you had a Pneumonia vaccination? If yes, when _____ and where_____?	O	O	O
Have you had Hepatitis B vaccination? If yes, when _____and where_____?	O	O	O
Have you had a Zoster (Shingles) vaccination? If yes, when_____ and where_____?	O	O	O

WOMEN:

Have you had a pap smear? If yes, when was your last one?_____ Hysterectomy?_____year	O	O	O
Have you had a mammogram? (age 35 and over) If yes, when was your last one? _____ History of breast cancer?___Yes ___No	O	O	O
Have you had a bone density test (DEXA)? If yes, when was your last one? _____ Have you been previously diagnosed with osteopenia or osteoporosis?___yes ___no	O	O	O