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 WELCOME TO MEDICARE (WTM) 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 WELCOME TO MEDICARE visit per lifetime within the initial 12 months of being effective with Medicare.**
*****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 a WTM visit otherwise you may be financially responsible for this visit**

Thank you for scheduling your **WELCOME TO MEDICARE**. 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 WELCOME TO MEDICARE 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 WELCOME TO MEDICARE 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 **WELCOME TO MEDICARE 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__________

WELCOME TO MEDICARE VISIT (IPPE) G0402

Please provide a complete list of the following items:

- List of your medications and vitamin supplements, including doses:

- LIST YOUR MEDICAL PROBLEMS

LIST YOUR SURGERIES with DATES

Surgery	Date

- ALLERGIES: ____________
- INJURIES: ____________
- HOSPITAL STAYS: ____________

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):

NAME________________________________ DOB________________ Date of Service: _____________

WELCOME TO MEDICARE

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

TOBACCO USE

2. 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 ______

ALCOHOL USE

3. 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

4. **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?		

PHYSICAL ACTIVITY

5. 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

6. 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.

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

8. **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______________________

9. 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

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

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

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

NOTE: Medicare allows one (1) "SCREENING EKG" per lifetime (screening=in the absence of a medical condition or symptoms) during a Welcome to Medicare Visit. If you would like to receive one please ask the provider about it. **Please be aware that it is subject to deductible and coinsurance so you may be financially responsible for this service.**

Advanced Directive:
Would you like to receive information about obtaining an Advanced Directive? ___YES ___NO

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

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	___	___	___