Patient Name:___________________________ Today's Date: _________________________

MEDICARE WELLNESS VISIT: Circle one:					Medicare		BCBS		Humana
DOB	**Gender**	**Height**	**Weight**	**BMI**	**BP**	**Temp**	**Pulse**	**Resp.**	**MR#**

Race: ☐American Indian ☐Alaska Native ☐Hawaiian ☐African American
☐White ☐Asian Pacific Islander ☐Other: ____________________________

Ethnicity: ☐Not Hispanic or Latino ☐Hispanic/Latino ☐Unknown

Language: ☐English ☐Spanish ☐Other: ____________________________

Marital Status: ☐Single ☐Married ☐Partnership ☐Separated ☐Divorced ☐Widowed

Yes No Have you been on Medicare less than 12 months?
Yes No Have you broken any bones in the last 12 months? Date:______________________
Yes No During the last 3 months have you leaked urine (even a small amount)?
Yes No Do you have an advance medical directive? (Living will and/or durable power of attorney for healthcare)? If no, would you like some information?_______________
Yes No Have you fallen in the last 12 months?

Social History

☐Yes ☐No Do you exercise? If yes, how often?___________Type of exercise:________________
☐Yes ☐No Do you eat 3 meals per day? If no, how many and when?___________________________
☐Yes ☐No Do you drink alcohol? If yes, how much?______Type of alcohol:____
☐Yes ☐No Do you drink caffeine? If yes, how much?______
☐Yes ☐No Do you currently use tobacco? If yes: # of years used:___Type of tobacco:
☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigar Quantity:_____
☐Yes ☐No Do you use illegal drugs or drugs for which they were not prescribed?
If yes: Type:__How used:___# of years using:____
☐Yes ☐No If you have more than one sexual partner, do you use protection against STDs?
☐Yes ☐No Have you received a blood transfusion before 1985?
☐Yes ☐No Have you received a tattoo before 1985?
☐Yes ☐No Do you use shared needles?

☐Yes ☐No Do you wear a seatbelt?
☐Yes ☐No Can you read and/or write?
☐Yes ☐No Do you live alone?
☐Yes ☐No Do you have caregiver or family support to assist with activities of daily living?
☐Yes ☐No Has a vision assessment been completed?

☐Yes ☐No Are you blind, or have severe vision impairment?
☐Yes ☐No Has a hearing assessment been completed?
☐Yes ☐No Do you have a hearing impairment?
☐Yes ☐No If yes, Do you wear a hearing aid?

Home Safety

☐Yes ☐No Does your home have rugs in the hallways?
☐Yes ☐No Does your home have grab bars in the bathroom?
☐Yes ☐No Does your home have handrails on the stairs?
☐Yes ☐No Does your home have good lighting in all rooms?

Patient Name:___________________________ Today's Date: _________________________

Hearing Screening

☐Yes ☐No Do you have a problem hearing over the telephone?
☐Yes ☐No Do you have trouble following the conversation when two or more people are talking at the same time?
☐Yes ☐No Do people complain that you turn the TV volume up too high?
☐Yes ☐No Do you have trouble hearing in a noisy background?
☐Yes ☐No Do you find yourself asking people to repeat themselves?

Activities of daily living screening

☐Yes ☐No Are you able to use a telephone without assistance?
☐Yes ☐No Are you able to shop for food and other necessities without help from others?
☐Yes ☐No Are you able to prepare simple meals by yourself?
☐Yes ☐No Are you able to dress, wash, and use the toilet without assistance?

☐Yes ☐No Are you able to transfer to and from bed and or chair without assistance?
☐Yes ☐No Are you able to do housework without assistance?
☐Yes ☐No Can you get to places outside of walking distance alone?
☐Yes ☐No Are you able to take your own medications and follow your diet correctly without help?
☐Yes ☐No Are you able to pay your bills and keep track of your check book balance and money without help?

Fall risk screening

☐Yes ☐No Have you fallen in the past year?
☐Yes ☐Sometimes ☐No Do you use a cane or walker?
☐Yes ☐Sometimes ☐No Do you steady yourself by holding onto furniture?
☐Yes ☐Sometimes ☐No Do you worry about falling?

☐Yes ☐Sometimes ☐No Do you push with your hands to stand up from a chair?
☐Yes ☐Sometimes ☐No Do you have some trouble stepping onto a curb?
☐Yes ☐Sometimes ☐No Do you often rush to the toilet?
☐Yes ☐Sometimes ☐No Have you lost some feeling in your feet?

Please list you allergies (medications and other allergies):

____

____

____

____

____

Please list any specialist (other doctors) you are seeing:

____

____

____

____

Patient Name:____________________________ Today's Date: __________________________

On a scale of 0-10, 10 being the worse, please rate your pain today: ____________________

*****Do you have an active prescription for an OPIOID?** **Yes** **No**

*****If yes, please answer the following questions:**
Potential Opioid Use Disorder (OUD) risk factors.

Mark each box that applies	Female mark here	Male mark here
1. Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
2. Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
3. Patient Age between 16—45 years	1	1
4. History of preadolescent sexual abuse	3	3
5. Psychological disease ADD, OCD, bipolar, schizophrenia	2	2
6. Depression	1	1
TOTAL:	_______	_______

FAMILY HISTORY

use ✓ to indicate positive history

	Self	Father	Mother	Sisters	Brother	Aunts	Uncles	Daughters	Sons
Hypertension									
Heart disease									
Stroke									
Kidney disease									
Obesity									
Genetic disorder									
Alcoholism									
Liver disease									
Depression or manic depressive									
Colon or rectal									
Breast cancer									
Other: __________									

Patient Name:___________________________ Today's Date: _________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
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. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
If you answered any of the above questions 1-3, 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?	0	1	2	3

********_**Depression screen score and follow up plan: _________________**_

ALCOHOL SCREENING	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
				Total	

Preventative services

Patient Name:____________________________ Today's Date: __________________________

Please tell us the date and provider name or where the service was done.

ALL AGES

FLU SHOT Date:________________ Where:____________________________

Over 65 years old

PNEUMONIA SHOT Date:________________ Where:_____________________Prevnar or Pneumovax?

AGE 18-75

Diabetic Eye Exam Date:________________ Where:____________________________

Age 45-75

Colorectal Screening Date:________________ Where:___________________Colonoscopy or Cologuard

Male Age 50-75

PSA blood test Date:________________ Where:____________________________

Female Age 24-64

Pap smear Date:________________ Where:____________________________

Female Age 50-74

Mammogram Date:________________ Where:____________________________

Patient Name:___________________________ Today's Date: _________________________

Mini-Cog Evaluation

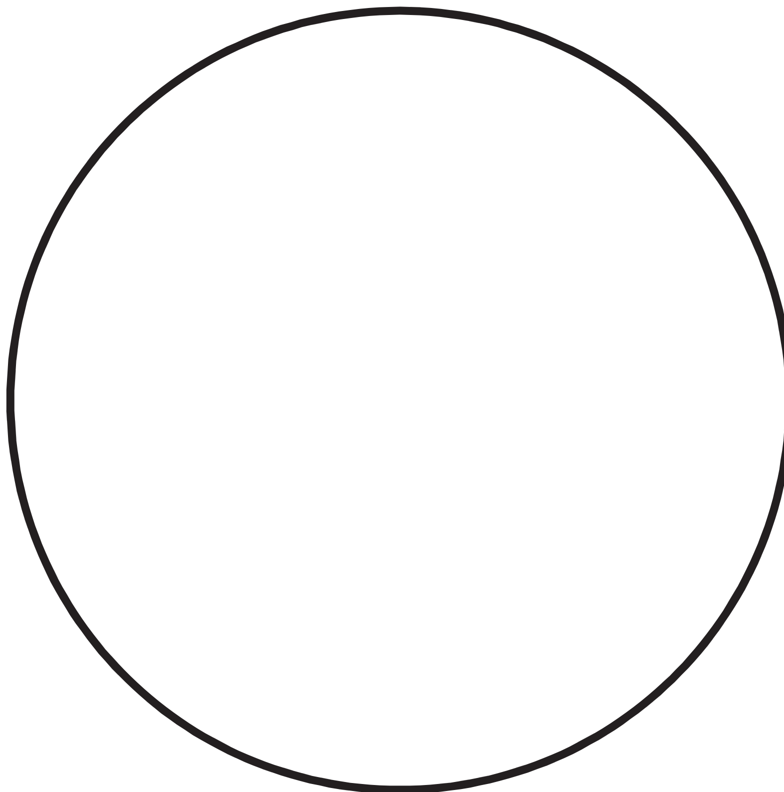
1. Ask patient to remember the following three words, and ask the patient to repeat the words to ensure the learning was correct. **BANANA SUNRISE CHAIR**

If the patient has done this test before you can choose to use another version of the three words.

Version 2	Version 3	Version 4	Version 5	Version 6
Leader	Village	River	Captain	Daughter
Season	Kitchen	Nation	Garden	Heaven
Table	Baby	Finger	Picture	Mountain

2. Ask patient to draw a clock. After numbers are on the face, ask patient to draw hands to read 20 minutes after 8 (or 10 minutes after 11).

Clock Drawing



3. Ask the patient to repeat the three words given previously.

Word List Version:___________________________Person's Answers: ___________________

Patient Name:____________________________ Today's Date: __________________________

1. **Yes** **No** Was the first yes/no patient question answered yes? If no, go to #2.

   If yes, ask Provider if patient needs a SNELLING and EKG.

   SNELLING Results: Left eye__________________ Right eye________________________

   EKG Results____

2. **Yes** **No** Was the second yes/no patient question answered yes?

   If yes, Fracture date____________________

   □Bone mineral density testing done within six months after the fracture? Date:________________

   □Osteoporosis med prescribed or taken within six months after the fracture? Date:____________

   □ **Excluded** due to bone mineral density testing being completed within 24 months prior to the fracture? Date?__________________________

   □**Excluded** due to osteoporosis therapy within 12 months before the fracture? Date:__________

   □**Excluded** due to patient is male or is not between 67-86 years old

3. **Yes** **No** Does patient have DM, CAD, or any type of high cholesterol?

   Yes **No** Is patient on a statin? If no, why?____________________________

4. **Yes** **No** Does patient have Rheumatoid Arthritis?

   Yes **No** Is patient on a DMARD? NAME:___________________________

5. **Yes** **No** Does patient have Diabetes?

   A1C Date:_________________ Result_______________________________

   Kidney tests Date:_________________ Result: Cre:___________Alb:__________Ratio____________

   Foot Exam

Pedal Pulses	(+2, +1, Trace, Absent)	___________Left		_____________Right	
Shape	(Normal or Abnormal)	___________Left		_____________Right	
Ulcers	(Yes or No)	___________Left		_____________Right	
Edema	(Yes or No)	___________Left		_____________Right	
Sensation	(using monofilament)	Right foot	_____No loss	______Yes loss	
		Left foot	_____No loss	______Yes loss	

6. **Yes** **No** Was a complete medication, including supplements, and allergy review done today with the patient and documented in the progress note for today's visit?

7. **Yes** **No** Was a complete **<u>Past Medical, Surgical, Social, and family history</u>** reviewed with the patient and documented in the progress note for today's visit?

<u>FOR OFFICE USE ONLY: Provider reviewed all of the above information with the patient.</u>

Physician's signature:____ Date:______________________