Medicare Annual Wellness Visit

****TO BE COMPLETED BY PATIENT****

Patient's Name: _____ **Age:** _____

Date of Exam: ___/___/_____ **Date of Birth:** ___/___/_____

Family History: _____

Are you currently seeing a Specialist or other providers? (List Providers) No☐Yes☐

Depression Screen (Complete the following questions, circle the response)

1. Over the last two weeks, have you felt down, depressed or hopeless? No☐Yes☐
2. Over the last two weeks, have you felt little interest or pleasure in doing things? No☐Yes☐

Hearing Loss Screen

1. Do you have trouble hearing the television or radio when others do not? No☐Yes☐
2. Do you have to strain or struggle to hear/understand conversations? No☐Yes☐

Function Screen

1. Do you need help with preparing meals, transportation, shopping, taking you medicine, managing your finances, or other activities of daily living? No☐Yes☐
2. Do you live alone? No☐Yes☐

Home Safety Screen

1. Does your home have throw rugs, poor lighting, or a slippery bathtub/shower? No☐Yes☐
2. Does your home LACK grab bars in bathrooms, handrails on stairs and steps? No☐Yes☐
3. Does your home LACK functioning smoke alarms? No☐Yes☐

Risk for falls Screen

1. Was the patient unsteady or take longer than 30 seconds during the timed "get up and go" test? No☐Yes☐

Detection of Cognitive/Memory Impairment: No☐Yes☐Notes: _____

Advanced Care Planning

1. Patient already has executed and Advance Directive? No☐Yes☐
2. If no, patient was given an opportunity to execute and Advance Directive today? No☐Yes☐
3. Physician statement "This individual has the ability to prepare an Advance Directive." No☐Yes☐
4. Physician has completed a physician order for life-sustaining treatment, or similar document of reflecting the patient's wishes for an advanced care plan. No☐Yes☐
5. Physician is willing to follow the patient's wishes. No☐Yes☐

Drug Allergies: _____
Have you ever used Tobacco? (circle) No☐ Yes☐Quit (year) _____
If yes, What Type (circle) Cigarettes☐Chew☐Pipe☐Cigar☐ _____ **packs/day for the last** _____ **years**
Alcohol use? No☐ Yes☐ ____drinks per ☐day ☐week ☐month
Recreational drug use? (circle) No☐Yes☐ Type(s): _____
What is your (current/former) occupation? _____
Who lives with you at home? _____
Do you exercise? No☐ Yes☐ If yes, _____**times per week Type:**_____
Are you on a special diet? No☐Yes☐ Why? _____
Do you always fasten your seat belt? No☐ Yes☐ Do you wear sunscreen? No☐Yes☐
Do you have any problems performing dressing, feeding, toileting, or grooming? No☐ Yes☐
Do you need help with shopping, food preparation, housekeeping, taking medicine or managing finances? No☐Yes☐

_____ _____

Patient Signature and Date **Physician Signature and Date**

Health ONE Denver Internal Medicine Physician Care℠

Annual Physical Exam Acknowledgement

An ***Annual Physical Exam*** is a "wellness" exam designed to provide a comprehensive physical examination in order to screen for disease, promote a healthy lifestyle, and assess a member's potential risk factors for future medical problems.

The Annual Physical Exam includes (based on CMS guidelines):

1. Health History Review
2. Vital signs
3. General appearance
4. Heart exam
5. Lung exam
6. Head and neck exam
7. Abdominal exam
8. Neurological exam
9. Dermatological exam
10. Extremities exam
11. Male physical exam
    - Testicular, hernia, penis, and prostate exams
12. Female physical exam
    - Breast and pelvic exams
13. Counseling to include healthy behaviors and screening services

Any health issues/problems not listed above are NOT considered part of a physical examination!

If you discuss other health concerns and or management of any health concern during your Physical Exam, **an office visit will be charged in addition to your physical and may generate a co-payment as a result.**

Because we care and want to provide you with the most efficient visit as possible, we will not ask you to make another appointment to discuss or manage your health concerns but please understand we are **legally obligated** to assign procedure codes based on the **service provided** to you.

We cannot change the coding later to cause the insurance company to pay for a non-covered service. If both services are billed you may be responsible for paying a co-payment for each service, depending on your insurance coverage.

By signing below, you have read and acknowledge the information stated above.

_____ _____

Patient signature Date

_____

Printed Patient Name