

	Medicare Wellness Visits	“Traditional” Physical Exam
<b>Primary Focus</b>	<ul style="list-style-type: none"> <li>Review/update health record</li> <li>Review/discuss risk factors associated with aging</li> <li>Discuss Preventive Services available and recommended through Medicare</li> <li>Discuss Healthcare Power of Attorney</li> </ul>	<ul style="list-style-type: none"> <li>Hands-on examination of all major body systems <ul style="list-style-type: none"> <li>Review/Update health record</li> <li>Check ears, eyes, nose and throat</li> <li>Listen to heart, lungs, bowels</li> <li>Check abdomen and extremities</li> <li>Perform neurological exam</li> <li>Dermatological (skin) examination</li> </ul> </li> </ul>
<b>Cost</b>	<p>These basic visits are <b>covered by Medicare at 100%</b>. You may be charged for an office visit if the provider addresses any health concerns during this visit (for example, you ask the provider to address your high blood pressure or diabetes or your back pain). The Wellness Visit will still be a no-charge visit, but you may have to pay a deductible and/or co-insurance for the services that are provided above and beyond those services covered by the Wellness Visit. To ensure adequate time is spent on the required elements of the Wellness Visit, you may be asked to schedule a follow-up visit to address existing or new problems.</p>	<p><b>Basic Medicare coverage does not cover the cost of a traditional physical exam.</b> If you have secondary coverage or a Medicare Advantage plan, you <u>may</u> have an annual physical covered as part of your benefits. Medicare Advantage plans and secondary insurance that does cover an annual physical will not cover the Medicare Wellness Visit and the Physical Exam during the same visit. As with the Medicare Wellness Visit, if your physician spends a significant portion of the visit addressing new or previously diagnosed medical problems, an office visit may be charged along with the physical exam. To ensure adequate time is spent on the “physical”, you may be asked to schedule a follow-up visit to address existing or new problems.</p>
<b>Physical Examination</b>	<p>Very limited exam</p> <ul style="list-style-type: none"> <li>Height, weight, blood pressure, pulse</li> <li>Basic hearing and vision screening</li> </ul>	<p>Comprehensive exam, which may include:</p> <ul style="list-style-type: none"> <li>Height, weight, blood pressure, pulse</li> <li>Head-to-toe checkup</li> <li>Review of all major body systems</li> <li>Gynecologic Exam (Females)</li> <li>Prostate Exam (Males)</li> </ul>
<b>Labs Performed</b>	<p>Based on personal/family history you <u>may</u> receive:</p> <ul style="list-style-type: none"> <li>Lipid Profile (Screening for cholesterol levels)</li> <li>Blood Glucose Level (Screening for diabetes)</li> <li>Hemocult (Screening for colon cancer)</li> <li>PSA (Screening for prostate cancer)</li> </ul>	<p>Based on personal/family history you <u>may</u> receive:</p> <ul style="list-style-type: none"> <li>Lipid Profile, Blood Glucose, Hemocult, PSA</li> <li>Comprehensive Metabolic Panel</li> <li>Complete Blood Count</li> <li>Thyroid Levels</li> <li>Additional Lab Tests based on results of examination</li> </ul>
<b>Immunizations</b>	<p>Discuss benefits of and provide covered immunizations</p> <ul style="list-style-type: none"> <li>Pneumovax</li> <li>Influenza (during flu season)</li> <li>Hepatitis B (based on risk)</li> </ul>	<p>Discuss benefits of and provide immunizations (not all covered by Medicare)</p> <ul style="list-style-type: none"> <li>Pneumovax</li> <li>Hepatitis B</li> <li>Influenza (during flu season)</li> <li>Shingles</li> <li>Tdap (Tetanus, diphtheria and pertussis)</li> </ul>
<b>Additional Testing</b>	<p>These additional procedures may be performed based on your risk factors:</p> <ul style="list-style-type: none"> <li>EKG (<b>small co-insurance may be charged</b>)</li> <li>Aorta Scan</li> </ul>	<p>Additional testing as indicated by personal and family history and medical examination</p>



# Medical History Form

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Gender: (Circle) Male / Female

Please list other physicians your are currently seeing and what you are seeing them for:  No other physicians

Physician	Reason

Please list any medications (to include over the counter and herbal) you are currently taking:  No current medications

Medication	Dose (mg, ml, etc.)	How taken (twice daily, a.m., as needed, etc.)

Please list any allergies you may have to medications, foods, plants, etc. and your reaction:  No known allergies

I'm allergic to:	Reaction	Estimated Date of Onset

Are you allergic to Shellfish, Iodine or Radiographic Dye? (Circle) Yes / No

Past Medical History: (Check all that apply)  No Past Medical History

<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Attack (MI)	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Peripheral Vascular Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Hernia	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer (Specify): _____	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Leg or Foot Ulcers	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Depression	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Ulcers (Stomach)
<input type="checkbox"/> GERD/Reflux	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Gout	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other _____

When/ where was your last Colonoscopy (Month/Year)? \_\_\_\_/\_\_\_\_  Not Applicable  
 When/ where was your last Eye Exam (Month/Year)? \_\_\_\_/\_\_\_\_  Not Applicable  
 Last Tetanus Vaccination \_\_\_\_/\_\_\_\_ Last Pneumonia Vaccination \_\_\_\_/\_\_\_\_ Last Shingles Vaccination \_\_\_\_/\_\_\_\_  
Month Year Month Year Month Year

**Gynecologic/Obstetric History (Female Only)**

When/ where was your last Mammogram (Month/Year)? \_\_\_\_/\_\_\_\_  Not Applicable  
 When/ where was your last Pap Smear (Month/Year)? \_\_\_\_/\_\_\_\_  Not Applicable  
 # of Pregnancies \_\_\_\_\_ # of Miscarriages \_\_\_\_\_ # of Children \_\_\_\_\_

**Please list the types and dates (Month/Year) of any surgeries:**

No prior surgeries

Type of Surgery	Month/Year of Surgery
	____/____
	____/____
	____/____

**Any past hospitalizations OTHER THAN for surgery (reason and date)? :**

No past hospitalizations

Hospitalizations Reason	Month/Year of Hospitalization
	____/____
	____/____
	____/____

**Family Medical History (Place a ✓ or ✗ in the box under the family member who has/had the health issue listed on the left)**

Health Condition	Mom	Mom's Mom	Mom's Dad	Dad	Dad's Mom	Dad's Dad	Brother	Sister	Aunt Uncle
Anxiety/Depression									
Cancer (Type(s): _____)									
Diabetes									
Heart Disease/Problems									
Hypertension									
Stroke/TIA									
Other (Explain: _____)									
Other (Explain: _____)									

Do you currently use tobacco? (Circle) No / Yes If yes, what type:  Cigarette  Cigar  Pipe  Chewing Tobacco

Do you have a PAST history of tobacco use? (Circle) No / Yes If yes, when did you quit? (Month/Year) \_\_\_\_/\_\_\_\_

Do you drink alcoholic beverages? (Circle) No / Yes If yes, please list the type of alcohol and how often/how much you consume: \_\_\_\_\_

Do you currently or have you ever used illicit/recreational drugs? (Circle) No / Yes

Marital Status:  Married  Single  Divorced  Separated  Widowed  Domestic Partner

Living arrangements:  Live alone  Live with someone else (Specify) \_\_\_\_\_

Exercise Level:  None  Occasional  Moderate  Heavy

Activities: \_\_\_\_\_

## Medicare Wellness Visit Health Risk Assessment

Today's Date: \_\_\_/\_\_\_/\_\_\_

Patient Name (Print): \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

1. During the past 4 weeks, how would you rate your health in general?

Excellent  Very Good  Good  Fair  Poor

2. In an average week, how many days do you exercise? \_\_\_\_\_ days

3. On days that you do exercise, how long do you typically exercise? \_\_\_\_\_ minutes a day

4. How intense is your typical exercise/physical activity?

Light (stretching/slow walking)  Moderate (brisk walking)  Heavy (like jogging/swimming)  
 Very Heavy (like running/stair climbing)  I am not currently exercising

5. How would you describe the condition of your mouth and teeth – including false teeth or dentures?

Excellent  Very Good  Good  Fair  Poor

6. In the past 7 days, how much bodily pain have you generally experienced?

No pain  Very mild pain  Mild pain  Moderate pain  Severe pain

7. Are you a smoker?  No  Yes Use smokeless tobacco?  No  Yes

8. If yes, would you be interested in quitting tobacco use within the next month?  Yes  No

9. In the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have?

10 or more drinks per week  6 – 9 drinks per week  2 - 5 drinks per week  
 One drink or less per week  No alcohol at all

10. During the past two weeks, how often have you felt down, depressed or hopeless?

Almost all the time  Most of the time  Some of the time  Almost never

11. During the past two weeks, how often have you felt little interest or pleasure in doing things?

Almost all the time  Most of the time  Some of the time  Almost never

12. During the past two weeks, how often have you felt anxious, nervous, or worried?

Almost all the time  Most of the time  Some of the time  Almost never

13. During the past two weeks, do you feel that you have had the social and emotional support you need?

Almost all the time  Most of the time  Some of the time  Almost never

14. Have your feelings caused you distress or interfered with your ability to get along socially with family and friends?  No  Yes

**Continue on reverse**

15. Do you require assistance performing any of the tasks listed below? Mark "No" if you can perform the task without assistance and "Yes" if you need assistance performing the task.

- a. Feed yourself  No  Yes If yes, who assists you? \_\_\_\_\_
- b. Getting in/out of bed  No  Yes If yes, who assists you? \_\_\_\_\_
- c. Getting on/off the toilet  No  Yes If yes, who assists you? \_\_\_\_\_
- d. Getting dressed  No  Yes If yes, who assists you? \_\_\_\_\_
- e. Bathing/showering/grooming  No  Yes If yes, who assists you? \_\_\_\_\_
- f. Walk across a room  
(includes using a cane or walker)  No  Yes If yes, who assists you? \_\_\_\_\_
- g. Prepare your own meals  No  Yes If yes, who assists you? \_\_\_\_\_
- h. Managing money/bills  No  Yes If yes, who assists you? \_\_\_\_\_
- i. Cleaning the house  No  Yes If yes, who assists you? \_\_\_\_\_
- j. Shopping (groceries/clothing)  No  Yes If yes, who assists you? \_\_\_\_\_
- k. Drive or use public transportation  No  Yes If yes, who assists you? \_\_\_\_\_
- l. Use technology (computer, TV, etc)  No  Yes If yes, who assists you? \_\_\_\_\_
- m. Take your medicines  No  Yes If yes, who assists you? \_\_\_\_\_

• How often do you have trouble taking medication the way you have been told to take them?

- I don't take medications  I always take them as prescribed  
 Sometimes I take them as prescribed  I seldom take them as prescribed

16. Have you fallen two or more times in the past year?  Yes  No

17. Are you afraid of falling?  Yes  No

18. Do you use seat belts when you are in a car?  Yes, usually  Yes, most of the time  No

19. Overall, how confident are you that you can control and manage most of your health problems?  
 Very confident  Somewhat confident  Not very confident  I have no health problems

20. Do you have an Advance Directive?  Yes  No

(a document that directs your health care wishes in the event you become ill)

- If you answered yes to #20, have you provided HCMA with a copy?  Yes  No  
• If you answered no, would you like information on Advance Directives?  Yes  No

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Provider Signature