	Medicare Wellness Visits	"Traditional" Physical Exam

Primary Focus	• Review/update health record
	• Review/discuss risk factors associated with aging
	• Discuss Preventive Services available and recommended through Medicare
	• Discuss Healthcare Power of Attorney
		• Hands-on examination of all major body systems
		  ○ Review/Update health record
		  ○ Check ears, eyes, nose and throat
		  ○ Listen to heart, lungs, bowels
		  ○ Check abdomen and extremities
		  ○ Perform neurological exam
		  ○ Dermatological (skin) examination

Cost	These basic visits are **covered by Medicare at 100%**. 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 be 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.	**Basic Medicare coverage does not cover the cost of a traditional physical exam.** If you have secondary coverage or a Medicare Advantage plan, you ***may*** 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.
Physical Examination	Very limited exam • Height, weight, blood pressure, pulse • Basic hearing and vision screening	Comprehensive exam, which may include: • Height, weight, blood pressure, pulse • Head-to-toe checkup • Review of all major body systems • Gynecologic Exam (Females) • Prostate Exam (Males)
Labs Performed	Based on personal/family history you ***may*** receive: • Lipid Profile (Screening for cholesterol levels) • Blood Glucose Level (Screening for diabetes) • Hemocult (Screening for colon cancer) • PSA (Screening for prostate cancer)	Based on personal/family history you ***may*** receive: • Lipid Profile, Blood Glucose, Hemocult, PSA • Comprehensive Metabolic Panel • Complete Blood Count • Thyroid Levels • Additional Lab Tests based on results of examination
Immunizations	Discuss benefits of and provide covered immunizations • Pneumovax • Influenza (during flu season) • Hepatitis B (based on risk)	Discuss benefits of and provide immunizations (not all covered by Medicare) • Pneumovax • Hepatitis B • Influenza (during flu season) • Shingles • Tdap (Tetanus, diphtheria and pertussis)
Additional Testing	These additional procedures may be performed based on your risk factors: • EKG (**small co-insurance may be charged**) • Aorta Scan	Additional testing as indicated by personal and family history and medical examination

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

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

Continue on Reverse

When/ where was your last Colonoscopy (Month/Year)? _____/_____ _____ ☐ Not Applicable

When/ where was your last Eye Exam (Month/Year)? _____/_____ _____ ☐ Not Applicable

Last Tetanus Vaccination ____/_____ (Month / Year) Last Pneumonia Vaccination ____/_____ (Month / Year) Last Shingles Vaccination ____/_____ (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**

_____

Provider Signature