ATTACHMENT B

Medicare Wellness Visit

Patient's Name:_____ D.O.B.____/____/____ Exam Date:_____

Allergies to
Meds:_____

Past personal illnesses, injuries, operations or diagnoses	Date	Hospitalized?

Tobacco use: YES ☐ NO ☐ If yes, (smoke or chew) How many per day? _____ Year you quit? _____
Alcohol Use: YES ☐ NO ☐ If yes,How many per day? _____ (Circle one) Beer, Wine or Hard liquor?
Drug Use: YES ☐ NO ☐ If yes, describe:_____

Prescriber	Medications, Supplements, Vitamins Name	Route (oral, topical. etc)	Dose	Frequency (ex. 1-2 times/day

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Current list of patient's providers and suppliers:

NAME	SPECIALTY	REASON

FAMILY HISTORY:

DISEASE	SPECIFICITY	FAMILY MEMBER	CAUSE OF DEATH Yes or no?
Cancer			
Diabetes	Type 1 or Type 2		
Heart Disease			
Genetic			
Psych			
Other			

How many times/week do you exercise? _____ Duration? _____ Type? _____

HEARING LOSS SCREEN:

1. Do you have trouble hearing the TV or radio when others don't? YES ☐ NO ☐
2. Do you have to strain or struggle to hear/understand conversations? YES ☐ NO ☐
3. Do you wear hearing aides? YES ☐ NO ☐

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FUNCTION SCREEN:

1. Do you need help with preparing meals, transportation, shopping, taking your meds, managing finances, or other activities of daily living? YES ☐ NO ☐
2. Do you live alone? YES ☐ NO ☐
3. Have there been any changes in your urination or bowel movements? YES ☐ NO ☐
   -Which one? _____

FALL SCREEN:

1. Have you had an injury from a fall in the past year? YES ☐ NO ☐
   If yes, when? _____
   What was the cause? _____
2. Have you had more than one fall in the last year? YES ☐ NO ☐

HOME SAFETY SCREEN:

1. Does your home have rugs, poor lighting, or a slippery Bathtub/shower? If yes, please circle which one YES ☐ NO ☐
2. Does your home LACK grab bars in bathrooms, handrails on stairs or steps? If yes, please circle which one YES ☐ NO ☐
3. Does your home LACK functioning smoke alarms? YES ☐ NO ☐

ADVANCE CARE PLANNING:

We would like to discuss your wishes and Advanced Directives with you. Please sign below if you will permit us to have this conversation.

1. Patient Consent: "I consent to discuss end-of-life issues with my healthcare provider."

_____ _____

Patient/Guardian Signature Date

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PRVENTATIVE SCREEN	MEDICARE COVERAGE	PREVIOUSLY TESTED DATE	SCHEDULED FOR SCREEN
Bone Mass measurement	Medicare Patients risk for developing osteoporosis		
Colorectal Cancer Screening(colonoscopy)	Medicare patients 50 and up		
Glaucoma/ Eye exam	Pts with diabetes, family hx of glaucoma		
Prostate Cancer Screening: PSA test	All Male patient 50 and older		
Screening Mammography:	All female patients 40 yrs and older		
Dental Exam			
VACCINES:	**BRAND**	**DOSES**	**DATE**
Covid			
Pneumococcal			
Influenza			
TD and Tdap			
RSV			
Shingrix			