Jackson Medical Group

1/01/2014

Medicare Annual Wellness Visit

If you have been enrolled in Medicare Part B for more than 12 months you are eligible to receive an ***Annual Wellness* Visit**, a yearly preventive visit covered by Medicare without a co-payment. It is a special type of evaluation that is primarily intended to help you and your medical provider develop a plan for determining and addressing potential medical problems. This type of visit requires that you and your provider address and evaluate specific issues with the intent of developing and/or updating a personalized *prevention* plan based on your current health and risk factors.

You are receiving this letter because you are scheduled for an upcoming *Annual Wellness Visit*. As mentioned above, Medicare requires that specific elements are addressed during this type of visit. As a result, we ask that you **please complete the attached form and bring it with you to your visit to review with your provider.** We also suggest that you bring all of your medications with you to your appointment to ensure that your provider obtains an accurate and complete list of all the medications you are currently taking, including the dosage of the medication and the frequency with which you take the medication.

In addition to the *Annual Wellness Visit (AWV)*, in 2014 Jackson Medical Group will offer the traditional annual checkup, including physical examination, at the same office visit that you have your Medicare *Annual Wellness Visit (AWV)*.

If at the conclusion of your visit, there is a pressing medical problem and if time permits, we will approach the problem. The evaluation and treatment of ongoing issues or newly-identified problems is **not** part of the preventative health evaluation and there **may** be an additional charge and copayment due. If time does not permit for evaluation of other symptoms, a followup appointment with applicable copayment will be scheduled.

Your signature on this page acknowledges that you have read and understand our policy on coding and billing for preventative visits.

Name: _____ Date:_____

Signature: _____

JACKSON
MEDICAL GROUP, INC.

Annual Wellness Visit

Date: _____

Patient: _____

DOB: _____

Please list any medical problems that pertain to you. Examples might include: Coronary artery disease, high blood pressure, seasonal allergies, etc.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list any surgical procedures or operations that you have undergone along with the year of the procedure:

Year:	Operation:
_____	_____
_____	_____
_____	_____
_____	_____

Please list any hospitalizations you have had in your lifetime. Please indicate the year and the reason you were hospitalized. You do not need to include visits to the Emergency Room.

Year:	Hospitalization:
_____	_____
_____	_____
_____	_____
_____	_____

Please list all prescription medications that you take, including the strength and how you take them. For example: Lipitor, 20 mg, one tablet each evening.

Medication:	Dose:	How taken:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Similarly, list all over-the-counter/non-prescription drugs and supplements that you take.

Medication:	Dose:	How taken:

Please list all of your healthcare providers and indicate the type of medical care each provides. Also, list any medical suppliers of durable medical equipment (eg CPAP supplies, diabetes supplies, etc).

Physician or supplier:	Type of practice or equipment provided:

Please give us the best information that you have for the following preventive services if they apply to you:

Preventive Service:	When and Where:
Last Mammogram?	_____
Last Bone Density Test (DEXA)?	_____
Colonoscopy or Flexible sigmoidoscopy?	_____
Abdominal Aortic Ultrasound?	_____
Pneumonia Vaccine (Pneumovax)?	_____
Shingles Vaccine (Zostavax)?	_____
Tetanus/diptheria Vaccine (Td) or Tetanus, diptheria and acellular pertussis Vaccine (Tdap)?	_____

Thank you!

Jackson Medical Group

MEDICARE WELLNESS CHECKUP

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

Your name: _____

Today's date: _____

Your date of birth: _____

1. What is your age?

☐ 65-69. ☐ 70-79. ☐ 80 or older.

2. Are you a male or a female?

☐ Male. ☐ Female.

3. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

4. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

5. During the **past four weeks**, how much bodily pain have you generally had?

☐ No pain.
☐ Very mild pain.
☐ Mild pain.
☐ Moderate pain.
☐ Severe pain.

6. During the **past four weeks**, was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

☐ Yes, as much as I wanted.
☐ Yes, quite a bit.
☐ Yes, some.
☐ Yes, a little.
☐ No, not at all.

7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

☐ Very heavy.
☐ Heavy.
☐ Moderate.
☐ Light.
☐ Very light.

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)

☐ Yes. ☐ No.

9. Can you go shopping for groceries or clothes without someone's help?

☐ Yes. ☐ No.

10. Can you prepare your own meals?

☐ Yes. ☐ No.

11. Can you do your housework without help?

☐ Yes. ☐ No.

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

☐ Yes. ☐ No.

13. Can you handle your own money without help?

☐ Yes. ☐ No.

14. During the **past four weeks**, how would you rate your health in general?

☐ Excellent.
☐ Very good.
☐ Good.
☐ Fair.
☐ Poor.

continued ➤

15. How have things been going for you during the **past four weeks**?

- ☐ Very well; could hardly be better.
- ☐ Pretty well.
- ☐ Good and bad parts about equal.
- ☐ Pretty bad.
- ☐ Very bad; could hardly be worse.

16. Are you having difficulties driving your car?

- ☐ Yes, often.
- ☐ Sometimes.
- ☐ No.
- ☐ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	☐	☐	☐	☐	☐
Sexual problems.	☐	☐	☐	☐	☐
Trouble eating well.	☐	☐	☐	☐	☐
Teeth or denture problems.	☐	☐	☐	☐	☐
Problems using the telephone.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

19. Have you fallen two or more times in **the past year**?

☐ Yes. ☐ No.

20. Are you afraid of falling?

☐ Yes. ☐ No.

21. Are you a smoker?

- ☐ No.
- ☐ Yes, and I might quit.
- ☐ Yes, but I'm not ready to quit.

22. During the **past four 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.

23. Do you exercise for about 20 minutes three or more days a week?

- ☐ Yes, most of the time.
- ☐ Yes, some of the time.
- ☐ No, I usually do not exercise this much.

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes. ☐ No.

Keeping track of your medications?

☐ Yes. ☐ No.

25. How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine.
- ☐ I always take them as prescribed.
- ☐ Sometimes I take them as prescribed.
- ☐ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident.
- ☐ Somewhat confident.
- ☐ Not very confident.
- ☐ I do not have any health problems.

27. What is your race? **(Check all that apply.)**

- ☐ White.
- ☐ Black or African American.
- ☐ Asian.
- ☐ Native Hawaiian or other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Family Practice Management®