Windsor Regional Medical Associates
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MEDICARE ANNUAL WELLNESS VISIT FORM

Name _______________________________________ Date_____________

The Medicare Annual Wellness Visit ("AWV") is meant to review your health status, update preventive care measures, and develop a plan for your continued good health. Medicare allows this visit once every 12 months.

By Medicare regulations, this Annual Wellness Visit <u>does not include</u> a complete physical examination or the evaluation or management of your other health problems. If provided, these services are billed separately.

During today's visit:

Do you want a complete physical examination? Yes No

Do you want to address your specific health issues? Yes No

Please list the names and specialty of all the other doctors that you see

(You may use the back for additional names)

Name Specialty

_____________________________ _____________________

_____________________________ _____________________

_____________________________ _____________________

_____________________________ _____________________

_____________________________ _____________________

Please list any over the counter medications you are taking:

_________________ ___________________ __________________

_________________ ___________________ __________________

Please list the names and doses for ALL prescription medications that you have (even if they are only taken "as needed"). Use the back if needed.

__________________ ___________________ ____________________

__________________ ___________________ ____________________

Name____ Date___________

Have you developed any other health issues since you were last seen? YES NO

If yes, please describe____

____

Have you fallen in the last year? YES NO If so, how many times_____

Do you feel unsteady walking? YES NO

Do you need an assistive device to walk (cane or walker)? YES NO

Do you have problems with urinary incontinence? YES NO

Do you have problems with bowel incontinence? YES NO

Have you seen an eye doctor in the last year? YES NO

Do you wear glasses or contacts? YES NO

Do you wear hearing aids? YES NO

Do you see a dentist at least once yearly? YES NO

Do you wear dentures? YES NO

Do you have an advanced directive (living will)? YES NO

If Yes, where is it located? _____________________________

Do you feel you have memory problems? YES NO

Do family members worry about your memory? YES NO

Do you feel down, depressed, or hopeless? YES NO

Do you have little interest in doing things? YES NO

Do you live alone? YES NO

Do You Drive? YES NO

Have you been involved in a motor vehicle accident recently? YES NO

How many alcoholic drinks do you have per week_________ or per month________?

Do you smoke? YES NO Did you ever smoke? YES NO

Name____ Date__________

Vaccines	Date	Frequency
Pneumonia vaccine	____________________	age 65 (repeat 10 yrs)
Zostavax (shingles vaccine)	____________________	once
Flu vaccine	____________________	Yearly
Tetanus/diphtheria	____________________	every 10 years

Screenings	Date	Frequency
Mammogram (females)	____________________	Yearly
Colonoscopy	____________________	every 1-10 years
PSA (males)	____________________	Yearly
EKG	____________________	Yearly if High BP
Cholesterol	____________________	6mo - yearly
Bone Density	____________________	Every 2 years

Name____ Date____________

Please review the following tasks and check off the box that best applies to you:

	I can do on my own	I need help	I cannot do
Bathing			
Eating			
Dressing			
Using the toilet			
Getting out of or into bed or a chair			
Manage medications			
Use the Telephone			
Arrange transportation			
Prepare meals			
Shopping			
Perform Housework			
Manage finances			

Home Safety – Self-Assessment

Are all poisons (eg, medications, detergents, insecticides, cleaning agents, polishes) kept out of reach of children and those with impaired cognitive function and discarded when no longer needed?	YES/NO
Are working smoke alarm(s) and fire extinguisher(s) available for use?	YES/NO
Is there an escape plan in case of fire or other disaster?	YES/NO
Have throw rugs been removed or fastened down?	YES/NO
Are all electrical cords in working order, easily seen, and not run under rugs/carpets or wrapped around nails?	YES/NO
Are non-slip mats in all bathtubs and showers?	YES/NO
Do all stairways have a railing or banister?	YES/NO
Are doorways, halls, and stairs free of clutter and adequately lit?	YES/NO
Are sidewalks and all outdoor steps clear of tools, toys, and other articles?	YES/NO

Name____ Date__________

Nutritional Assessment

	Yes	No	Score
I have an illness or condition that made me change the kind and/or amount of food I eat.			2
I eat fewer than 2 meals per day			3
I eat few fruits or vegetables or milk products.			2
I have 3 or more drinks of beer, liquor or wine almost every day.			2
I have tooth or mouth problems that make it hard for me to eat.			2
I don't always have enough money to buy the food I need.			4
I eat alone most of the time.			1
I take 3 or more different prescribed or over-the-counter drugs a day.			1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.			2
I am not always physically able to shop, cook and/or feed myself.			2

Name____ Date____________

Based upon your responses to the questionnaire and our discussion today, the following recommendations have been made for you if circled:

Increase weight bearing exercise

Calcium 600mg and Vitamin D 400 IU combination pill twice daily

Aspirin 81 mg daily

Annual eye exam

Regular dental visits

Driver evaluation

Further memory testing

Advance care planning

Contact your gastroenterologist to determine when next colonoscopy is due

Physical Therapy

Zostavax (shingles vaccine)

Return to our office to further discuss _____________________________