Medicare Wellness: Health Risk Assessment

Patient Name: __________________________ Date of Birth: ____________ Date: ____________

1. In general, would you say your health is: _____Excellent _____Very Good _____Good _____Fair _____Poor

2. How have things been going for you during the past 4 weeks?
____Very well; could hardly be better
____Pretty well
____Good and bad parts about equal
____Pretty bad
____Very bad; could hardly be worse

3. How confident are you that you can control and manage most of your health problems/issues?
____Very confident
____Somewhat confident
____Not very confident
____I do not have any health problems

4. How often in the last 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up					
Sexual problems or concerns					
Trouble eating/swallowing					
Teeth or denture problems					
Problems using the telephone					
Tiredness or fatigue					
Problems sleeping					

5. Have you fallen two or more times in the past year? _____YES _____NO

6. Are you afraid of falling? Do you feel unsteady? _____YES _____NO

7. HOME SAFETY CHECKLIST

	Yes	No
Are entrance ways well lit?		
Are sidewalks/entrance ways maintained?		
Is a carbon monoxide detector installed?		
Are smoke detectors installed?		
Are all medicines kept in original containers with original labels intact?		
Do you throw out all unidentified or out-of-date medications?		

8. 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 directed
____Sometimes I take them as directed
____I seldom take them as directed

9. Are you having difficulties driving your car? ____Yes, often ____Sometimes ____No ____I do not use a car

10. Do you always fasten your seat belt when you are in a car?
____Yes, always/usually
____Yes, sometimes
____No

11. How often in the last four weeks have you experienced the following?

Hearing loss screening	Never	Seldom	Sometimes	Often	Always
Straining to understand conversation					
Trouble hearing in a noisy background					
Misunderstanding what others are saying					

12. During the past 4 weeks how much have you been bothered by feelings of anxiety, depression, irritability, or sadness? _____Not at all _____Quite a bit _____Slightly _____Moderately _____Extremely

13. During the past 4 weeks, has your physical or emotional health limited your social activities with family andfriends? _____Not at all _____Quite a bit _____Slightly _____Moderately _____Extremely

14. During the past 4 weeks, how much bodily pains have you generally had?
_____No Pain _____Very Mild Pain _____Mild Pain _____Moderate Pain _____Severe Pain

15. Do you have someone who is available to help you if you needed or wanted help?
____Yes, as much as I want / need
____Yes, some
____No, not at all

16. Because of any health problems, do you need the help of another person with shopping, preparation of meals,or housework? _____Yes _____No

17. Because of any health problems, do you need the help of another person with your personal care needs, suchas eating, bathing, dressing, or getting around the house? _____Yes _____No

18. Can you handle your own money without help? _____Yes _____No

19. During the past 4 weeks, did you exercise for about 20 minutes, 3 or more days a week?
____Yes, most of the time
____Yes, some of the time
____No, I usually do not exercise this much
____No, I am not currently exercising

20. When you exercise, how intensely to you typically exercise?
____Light (stretching/slow walking)
____Moderate (brisk walking)
____Heavy (jogging/swimming)
____Very Heavy (running/stair climbing)

21. Are you a smoker/tobacco user?
__No – never
__No – former; when did you quit? ________________________________
__Yes, and I am interested in quitting. How many packs/day on average? _____ For how many years? _____
__Yes, but I'm not ready to quit. How many packs/day on average? _____ For how many years? _____

22. Alcohol History. Did you have a drink with alcohol in the past year? _____Yes _____No

If yes, continue. If no, skip to next section
How often did you have a drink containing alcohol in the past year?
_____Monthly _____2-4x/month _____2-3x/week _____4 or more times/week

How many drinks did you have on a typical day when you were drinking in the past year?
_____1-2 drinks _____3-4 drinks _____5-6 drinks _____7-9 drinks _____10 or more drinks

How often did you have 6 more drinks on one occasion in the past year?
_____Never _____Less than monthly _____Monthly _____Weekly _____Daily or almost daily

23. Do you have any urinary accidents (or are you scared you are going to have one)? _____Yes _____No

24. Vaccination Record

	Last Infection Date	Date received Circle One	Given by
COVID-19?	____N/A	Dose 1 __________ Moderna Pfizer J&J Dose 2 __________ Moderna Pfizer J&J Dose 3 __________ Moderna Pfizer J&J Dose 4 __________ Moderna Pfizer	_______________________ _______________________ _______________________
Flu	____N/A		
Pneumonia	____N/A		
Tetanus	____N/A	TdaP Td	
Shingles	____N/A	1 shot shingles 2 shot Shingrix	

25. Health Record

Test	Date of test/procedure (most recent)	Result	Treatment
Cholesterol/lipid levels			
DEXA Scan (bone density)		_____Normal _____Abnormal	
Rectal exam		_____Normal _____Abnormal	
Colonoscopy		_____Normal _____Abnormal	
Next colonoscopy?			

26. Do you have a cardiologist? _____Yes _____No Last echo? ________________________________

Last name: ____________________

Date of birth: __________________

27. Are you having memory issues, foggy brain or dizziness? _____Yes _____No

28. Are you having pain, burning, numbness or tingling in your arms or legs? _____Yes _____No

29. Diabetics History. ***Skip if this does not apply***
Diagnosis date? _____________________Type I Type II Mixed

HbA1c last checked? _________________ What was the value? ________

Last diabetic eye exam? _______________Last diabetic foot exam? ______________

30. Women
Are you doing monthly self-breast exams? Yes/No
Last mammogram? __________ Normal/Abnormal Next mammogram? ___________
Last pap smear? __________ Normal/Abnormal Next pap smear? ___________

Men
Are you doing monthly self-breast exams? Yes/No
Are you doing monthly self-testicular exams? Yes/No

Clinical Checklist:
- ☐ Height, weight, BMI
- ☐ Blood pressure
- ☐ Visual acuity screen (eye chart)
- ☐ Advanced directive and end-of-life planning
- ☐ Counseling/education aimed at preventing chronic diseases, reducing risk factors, promoting wellness, and improving self-management of health
- ☐ Screening schedule for the next 5-10 years

Last name: ____________________

Date of birth: __________________

Patient Health Questionnaire (PHQ –9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or hurting yourself	0	1	2	3
Add columns		+	+	
Total				

(Healthcare professional: For interpretation of TOTAL please refer to accompanying scoring card)

10. If you checked off any problems, how difficult have these problems made it for you to do yourwork, take care of things at home, or get along with other people?
    _____ Not difficult at all
    _____ Somewhat difficult
    _____ Very Difficult
    _____ Extremely Difficult

Provider Initials _________

Last name: ____________________

Date of birth: __________________

List of Providers & Suppliers of Healthcare

Please list all your current providers and suppliers of healthcare

Primary Care Physician/provider(s):

Clinic/Provider Name	Location

Specialist(s):

Clinic/Provider Name	Specialty	Phone number

Alternative medicine providers (i.e., chiropractors, acupuncturists, etc.):

Clinic/Provider Name	Specialty	Phone number

Preferred pharmacy(s): Name & Location

Pharmacy Name	Location	Phone

Dentist:

Clinic/Dentist Name	Location

Other:

Last name: ____________________

Date of birth: __________________

Medicare Wellness: Patient Packet

_______Medicare's **"Welcome to Medicare" Visit (a.k.a IPPE)** *Medicare Wellness*(Benefit available 1 time in your first 12 months of enrollment with Medicare Part B)

_______Medicare's **Annual Wellness Visit** *Medicare Wellness*
(For beneficiaries past their first 12 months of Medicare Part B enrollment and 12 months after a Welcome to Medicare exam, if that was received)

_______**Regular Adult CPX ("physical exam")**

- Medicare Part B primary: This service continues to be **non-covered** by original Medicare Part B. Medicare will deny this service and payment will be your responsibility. If you qualify and would prefer to receive one of Medicare's covered Wellness services (i.e., Welcome to Medicare or Annual Wellness Visit), complete the attached forms & questionnaires and presentthem at the time of your appointment.)
- Medicare Advantage primary (i.e. Medicare Part C / Replacement Plan): Please check with your insurance plan to verify your benefits and coverage for this routine annual physical exam service.

Enclosed you will find the Patient Questionnaire packet required for the covered *Medicare Wellness* services. Please make sure your name and date of birth are on each page.

It includes:
• Materials explaining the *Medicare Wellness* benefits & what to expect
• Health Risk Assessment (HRA) form
• Depression Screening Questionnaire (PHQ-9)
• List of Providers & Suppliers of Healthcare form

Please complete all the enclosed questionnaires ***prior to your appointment***. Please bring all of the completed questionnaires with you to your appointment and give them to your provider. Your provider will go over these documents as part of your service.

Thank you! We are looking forward to seeing you.

Last name: ____________________

Date of birth: __________________

*Medicare Wellness" Visits

IMPORTANT: The three Medicare-created *wellness visits* are focused on wellness, risk-factor reduction, and prevention. They are **not the same** as a "routine physical checkup" or "routine annual exam". There continues to be **no coverage from Medicare for traditional, age-specific physicals.**

These 3 Medicare-created *wellness visits* are covered by Medicare at 100%, without deductible or coinsurance, as long as the frequency limits are not exceeded.

1. **"Welcome to Medicare" or IPPE**: once per lifetime in the first 12 months of Part B enrollment
2. **Annual Wellness Visit, initial**: once per lifetime after the first 12 months of Part B enrollment and at least 12 months after a "Welcome to Medicare" visit (if applicable).
3. **Annual Wellness Visit, subsequent**: once every 12 months; the first one is at least 12 months after the initial Annual Wellness Visit

These *wellness visits* **do not include** any clinical laboratory tests, but the provider may separately order such tests during one of these visits. All laboratory tests are subject to Medicare's applicable coverage guidelines and frequency limits. Deductible and coinsurance may be applied.

The *wellness visits* **do not include** other routine preventive services that Medicare covers (i.e., Pelvic/Breast exam, Pap smear, Influenza and pneumonia vaccines, smoking cessation counseling, etc.). These services can be provided alongside one of the *wellness visits* and billed separately to Medicare. These services are subject to their own Medicare coverage guidelines and frequency limits. Deductible and coinsurance may be applied.

An additional office visit (E&M) service can be provided alongside one of the *wellness visits* and billed separately to Medicare if it is significant, separate and medically necessary to treat a new or established health problem. This service is subject to its own Medicare coverage guidelines and limitation. Deductible and coinsurance will be applied.

For additional information about any of Medicare's service you can go to Medicare's beneficiary website at www.medicare.gov.

Last name: ____________________

Date of birth: __________________

What to expect from your Medicare Wellness Visit:

Elements	What to expect
History	Review of your medical and social history Past medical and surgical history Current medications and supplements Family medical history History of alcohol, tobacco and/or drug use Diet and exercise Anything else the provider deems appropriate
Identifying Risk Factors	You complete standardized screening questions for: Depression Hearing impairment Activities of daily living Fall risk/home safety Provider reviews results to identify possible risk factors
Health Risk Assessment (HRA)	In written form, self-report information including screening questions in Risk Factor categories, self-assessment of health status, psychosocial risks, behavioral risks, et.
Problem list/interventions	Establish a list of your risk factors and condition for which you are being treated or treatment is recommended
Current Providers/Suppliers	Establish a list of your current providers and suppliers of healthcare
Detection of Cognitive Impairment	Through direct observation and discussion with you and/or your family/caregivers, provider will assess if there is any cognitive impairment
Exam	Obtain the following: Height and weight & calculate BMI Blood pressure Visual acuity screen (eye chart) Anything else the provider deems appropriate
Voluntary Advance Care (end-of-life) Planning	Upon your consent, gather/provide information on advanced directive and end-of-life planning. You can decline to discuss.
Personalized Health Advice	Counseling/education and/or referral for counseling/education aimed at preventing chronic diseases, reducing your identified risk factors, promoting wellness, and improving self-management of your health
Screening/Preventive services schedule	Establish a written screening schedule, covering the next 5-10 years (checklist) of recommended/appropriate covered preventive services. Receive a brief written plan (checklist) of recommended/appropriate screening and preventive services that are covered benefits under Medicare.