Revere Health
Let's live better.

MEDICARE WELLNESS VISIT

Your preventive visit will assess the following:

- your medical and surgical history
- your current medications
- your relevant family history
- your use of any alcohol, tobacco, or illicit drugs
- your current physical activity
- any other providers/suppliers involved in your care
- any depression, cognitive impairment, or safety concerns
- an exam of your height, weight, body mass index and blood pressure
  any "end of life" planning concerns

The visit concludes with the following:

- development of a list of any identified preventive health concerns
- education, counseling, and referrals based on any such concerns
- a personalized written "screening schedule" detailing any recommended screening/preventive services that are covered by Medicare

The visit will not include:

- Refills of chronic medications or prescription of new medications
- evaluation of status of chronic diseases such as diabetes, high blood pressure, high cholesterol, heart diseas, arthritis, urinary symptoms, etc.
- actual perfomance of a preventive service, such as PAP smear or prostate exam
- an actual physical exam (such as looking at the skin, listening to the heart and lungs, etc.
- blood tests to follow any condition the patient is known to have or to diagnose any condition except for a few screening tests Medicare covers

PLEASE NOTE: Per Medicare, this annual Medicare Wellness Visit is intended to be a "wellness" visit, limited to health promotion and disease prevention. To the extent that you and your doctor spend any time during your doctor spend any time during your preventive visit addressing non-preventive issues such as illnesses, diseases, and/or injuries that you may have, Medicare has directed us to code and bill for such services separately and in addition to the preventive visit. We mention this in advance of your exam so that you are aware that you may incur charges for this visit, depending on the extent of the exam and any copays and/or deductibles you may be responsible for through your Medicare coverage.

To get started, please complete the following 4 pages of questions,

to the best of your ability,

IN ADVANCE of your visit with the doctor.

Patient Name:	Date of Birth:

You have been scheduled for a **Medicare Wellness Visit**. The following information is needed to complete your visit. Please fill in all the information requested. If more space is needed, you may use the back of the forms.

CURRENT MEDICAL PROBLEMS

Active Problems: List any current medical problems or conditions	

PAST MEDICAL HISTORY

Past Medical History: List any previous medical illness, diseases, health problems that no longer need treatment (i.e. child hood illnesses, pneumonia, alcohol abuse, prostate cancer, etc.)

Childhood Illness	

Chronic Illnesses	

Past Surgeries	

FAMILY HISTORY

FAMILY HISTORY	Self	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Sisters	Brothers	Aunts Uncles	Children
Deceased	○	○	○	○	○	○	○	○	○	○	○
High Blood Pressure	○	○	○	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○	○	○	○	○
High Cholesterol	○	○	○	○	○	○	○	○	○	○	○
Stroke	○	○	○	○	○	○	○	○	○	○	○
Thyroid Disorder	○	○	○	○	○	○	○	○	○	○	○
Kidney Disease	○	○	○	○	○	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○	○	○	○	○	○
Mental Disease	○	○	○	○	○	○	○	○	○	○	○
Colorectal Cancer	○	○	○	○	○	○	○	○	○	○	○
Prostate Cancer	○	○	○	○	○	○	○	○	○	○	○
Breast Cancer	○	○	○	○	○	○	○	○	○	○	○
Other	○	○	○	○	○	○	○	○	○	○	○

SOCIAL HISTORY

Have you ever smoked tobacco? ◯Yes ◯No How many years? _____

How many packs per day? _____ How many cigarettes per day? _____

Have you ever used smokeless tobacco? ◯Yes ◯No

Do you drink alcohol? ◯Yes ◯No ◯Rarely ◯Occasionally ◯Frequently

◯Binge Drinking ◯In Recovery

Do you use illicit drugs? ◯Never ◯Former ◯Current ◯ Occasional User

Type of Drug: ◯Marijuana ◯Cocaine ◯Steroids ◯Sedatives ◯Methamphetamine

◯IV Drugs ◯Oral Opioids (hydrocodone, oxycontin, codeine, etc.) ◯ Hallucinogens

MEDICATIONS

Current Medications (May use back of page if needed)

Name	Strength/MG	How Taken	Prescribing Physician

Over-the-Counter Medications (non-prescription)

Name	Strength/MG	How Taken

Supplements: Please list all herbal preparations, vitamins and minerals that you take daily.

Name	Strength/MG	How Taken

ALLERGIES

Allergies to Medications or X-ray Dyes:

Medication	Reaction

IMMUNIZATIONS

Vaccine	Date (s) Received.	Vaccine	Date (s) Received.
Flu Vaccine		Hepatitis A Series	
Pneumonia vaccine		HIB	
Hepatitis B Series		MMR	
Zostavax		Polio	
Td Tetanus		Varicella	
Tdap Tetanus/Diphtheria Vaccine		Other	

HEALTHCARE PROVIDERS

Other Physicians/Providers of care (i.e. cardiology, pulmonology, home health, oxygen, medical equipment)

Provider Name	Specialty

Patient Healthcare Questionnaire

Please select the best answer:

Over the past 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 Every Day
Little interest or pleasure in doing things	◯	◯	◯	◯
Feeling down, depressed or hopeless	◯	◯	◯	◯
Trouble falling or staying asleep, or sleeping too much	◯	◯	◯	◯
Feeling tired or having little energy	◯	◯	◯	◯
Poor appetite or overeating	◯	◯	◯	◯
Feeling bad about yourself, or feel like a failure, or have let yourself or your family down	◯	◯	◯	◯
Trouble concentrating on things, such as reading the paper or watching TV	◯	◯	◯	◯
Moving or speaking slowly or being fidgety	◯	◯	◯	◯
Thoughts that you would be better dead or of hurting yourself	◯	◯	◯	◯

Please select the best answer the following questions:

Are you satisfied with your life? ◯ Yes ◯No
Do you feel that your life is empty? ◯Yes ◯No
Are you afraid that something bad is going to happen to you? ◯Yes ◯No
Do you feel happy most of the time? ◯Yes ◯No

Has your hearing decreased? ◯Normal ◯Slightly Decreased ◯Significantly Decreased
Do you use a hearing aid? ◯Yes ◯No

Do you need help with any of the following activities?
◯Using the Phone ◯Transportation ◯Shopping ◯Preparing Meals ◯Doing Housework
◯Doing Laundry ◯Managing Medications ◯ Managing Money

Do you have any of the following risks for fall?
◯Multiple Medications ◯Alcohol Use ◯Mobility Impairment ◯Antidepressant Use
◯Weaknesses ◯Positional Hypotension ◯Sedative Use ◯Visual Impairment
◯Urinary Incontinence ◯High Blood Pressure Medication ◯Cognitive Impairment
◯Unsteady ◯Previous Fall

Do you have any of the following home safety risk factors?
◯ Unfamiliar Surroundings ◯Loose Rugs ◯Poor Household Lighting ◯Uneven Floors
◯ Household Clutter ◯No Grab Bars in Bathroom ◯No Handrails on Stairs

Please select the best answer for the following:

Bathing - either sponge bath, tub bath, or shower

◯ **Receives no assistance (gets in and out of tub/shower by self)**
◯ **Receives assistance in bathing only one part of the body (such as back or a leg)**
◯ **Receives assistance in bathing more than one part of the body (or not bathed)**

Dressing - gets cloths from closet and drawers - including underclothes, outer garments, and using fasteners

◯ **Gets clothes and gets completely dressed without assistance**
◯ **Gets clothes and gets dressed without assistance except for assistance in tying shoes**
◯ **Receives assistance getting clothes or getting dressed, or stays partly or completely undressed**

Toileting - going to the "toilet room" for bowel or urine elimination, cleaning self after , and arranging clothes

◯ **Goes to the bathroom, cleans self, arranges clothes without assistance**
◯ **Receives assistance in the bathroom or in cleaning self or arranging clothes after elimination**
◯ **Doesn't go to room termed "toilet" for elimination process**

Transfer

◯ **Moves in and out of bed/chair without assistance (may use cane or walker)**
◯ **Moves in and out of bed/chair with assistance**
◯ **Doesn't get out of bed**

Continence

◯ **Controls urination and bowel movement completely by self**
◯ **Has occasional "accidents"**
◯ **Supervision helps keep urine/bowel control, catheter is used, or is incontinent**

Feeding

◯ **Feeds self without assistance**
◯ **Feeds self except for getting assistance in cutting meat or buttering bread**
◯ **Receives assistance in feeding or is fed partly or completely by tubes/intravenous fluids**

Do you have an Advanced Directive? ◯**Yes** ◯**No** **Living Will?** ◯**Yes** ◯**No**

Do you have a Durable Power of Attorney for Healthcare? ◯**Yes** ◯**No**

Please bring these completed forms with you to your Medicare Wellness Visit.

Thank you !