Stone Mountain Family Practice, P.C.

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A WORD TO OUR PATIENTS ABOUT MEDICARE AND WELLNESS CARE

We want you to receive wellness care- health care that may lower your risk of illness or injury. Medicare pays for some wellness care, but it does not pay for all the wellness care you might need. We want you to know about your Medicare benefits and how we can help you get the most from them.

The term "physical" is often used to describe wellness care. But Medicare does not pay for a traditional, head-to-toe physical. Medicare does pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:

Screenings to detect depression, risk for falling and other problems,

A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender, and level of activity,

Recommendations for other wellness services and healthy lifestyle changes.

Before your appointment, our staff will ask you some questions about your health and may ask you to fill out a form. If you prefer, you can print and fill out the form from our website and bring it with you to your Medicare wellness visit.

A wellness visit does not deal with new or existing health problems. That would be a separate service and requires a longer appointment. Please let our scheduling staff know if you need the doctor's help with a health problem, a medication refill or something else. We may need to schedule a separate appointment. A separate charge applies to these services, whether provided on the same date or a different date than the wellness visit.

We hope to help you get the most from your Medicare Wellness benefits. Please contact us with any questions.

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.

1. What is your age?

__ less than 65 __ 65-69 __ 70-79 __ 80 or older

2. Gender?

__ Male
__ Female
__ Transgender
__ Decline to answer

3. Who do you live with?

__ Alone
__ Spouse
__ Family
__ Other

4. During the **past 2 months**, 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 2 months**, have you experienced fatigue or a lack of energy?

__ Not at all
__ Slightly
__ Moderately
__ Quite a bit
__ Extremely

6. On a scale from 0-10 (10 being the WORST pain), During the **past 2 months**, how much bodily pain have had? Circle Below

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Your name: _____

Today's date: _____

Your date of birth: _____

7. In the **last 7 days,** did you need help from others to perform any of the following everyday activities: eating, getting dressed, grooming, bathing, walking, or using the toilet?

__ Yes __ No

8. During the **past 2 months**, what was the hardest physical activity you could do for at least two minutes?

__ Very heavy
__ Heavy
__ Moderate
__ Light
__ Very light

9. In the **last 7 days,** did you need help from others to perform any of the following everyday activities: laundry and housekeeping, banking, shopping, food prep, transportation, or taking your own medications?

__ Yes __ No

10. Do you or anyone you know have concerns about your driving abilities?

__ Yes __ No

11. Do/does furniture, rugs, cords, or poor lighting present difficulty with getting around your house?

__ Yes __ No

12. Are any of the stairs/steps in your home broken or uneven?

__ Yes __ No

13. Do any of the stairs/steps in your home include handrails?

__ Yes __ No

14. Do you have any teeth or denture problems?

__ Yes __ No

Indicate your last time at the Dentist:

_____

15. Do you wear glasses or contacts?

__Yes __ No

Indicate your last time at the Eye Doctor:

_____

16. Do you have trouble hearing the TV when others don't or straining to hear conversations?

__ Yes __ No

17. Do you wear hearing aids?

__ Yes __ No

18. Do you have any speech problems?

__ Yes __ No

19. During the **past 2 months**, how would you rate your health in general?

__ Excellent
__ Very good
__ Good
__ Fair
__ Poor

Your name: _____

Your date of birth: _____

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

__ Yes __ No

21. Is stress a problem for you in handling your health, finances, family relationships, or other relationships?

__ Yes __ No

22. In the **past four weeks,** how often have you experienced anger?

__ Not at all
__ Slightly
__ Moderately
__ Quite a bit
__ Extremely

23. Are you having difficulties driving your car?

__ Yes, often
__ Sometimes
__ No
__ Not applicable, I do not use a car

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

__ Yes, always
__ Yes, sometimes
__ No

26. Do you use anything to help you ambulate?

__ independent
__ wheelchair
__ walker
__ cane

27. Have you fallen 1 or more times in **the past year**?

__ Yes __ No If YES—WHEN? ____

Were you injured __Yes __No

28. Are you afraid of falling?

__ Yes __ No

29. Are you a smoker?

_ No
_ Yes, and I might quit
_ Yes, but I'm not ready to quit

30. During the **past 2 months**, 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

31. 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

32. What is your current physical activity as compared to last year?

__ More
__ Less
__ Same

33. 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

Your name: _____

Your date of birth: _____

34. 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

35. Do you have difficulty controlling your bladder?

__ Yes __ No

36. Do you have difficulty controlling your bowels?

__ Yes __ No

37. Are you sexually active?

__ Yes __ No

38. Have you used drugs other than those required for medical reasons?

__ Yes __ No

39. Do you have a Living Will/Advance Directive? (document of your healthcare wishes)

__ Yes __ No

40. Do you have a Power of Attorney? (someone to make medical decisions for you in the event you are unable to)

__ Yes __ No

Name: _____ Date of Birth: _____ Date: _____

Patient Health Questionnaire (PHQ-9)

In the **past 2 weeks**, how often do you have these symptoms?

(Circle the answer that best matches how you feel)

QUESTION	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

History and Information Forms

Name: _____ Date of Birth: _____ Date: _____

Instructions:

Please provide the following information before seeing your doctor—your accurate responses will help us make sure you receive the best care possible. See the front desk staff if you have any questions while completing the form.

Hospitalizations and Emergency Room Visits

Instructions:

Please list the names of hospitals at which you have stayed overnight and the emergency rooms you have visited during the **past 12 months**, as well as the date and the reason for your visit or stay, if applicable.

Type of Visit: ER	Type of Visit: Hospital Stay	Name of Facility	Date	Reason for Visit/Overnight Stay
☐	☐			
☐	☐			
☐	☐			

Medical Equipment Suppliers

Instructions:

Please list the names of all your medical equipment supply companies (e.g., oxygen tank supplier), if applicable.

Equipment	Name of Company

Name: _____ Date of Birth: _____ Date: _____

Providers and Specialists

Instructions:

Please list the names of all the healthcare providers you see outside our office, including specialists (e.g., eye doctor, cardiologist, foot doctor, home health agency, etc.), if applicable.

Provider Name	Specialty

Allergies

Instructions:

Please list your allergies, their severity, and whether or not this is a new or existing allergy, if applicable.

Allergy	Severity	Onset (New/Existing)