Stone Mountain Family Practice, P.C.

1805 Parke Plaza Circle
Suite 101
Stone Mountain, Georgia 30087
770-469-7000
Fax: 770-879-0436

MARTHA CRENSHAW, M.D., F.A.B.F.P. **S. CATHERINE HUGGINS, M.D.,F.A.B.F.P.**

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.

Your name: ______________________________________

Today's date: ____________________________________

Your date of birth: ______________________________

1. What is your age?

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

2. Are you a female or a male?

_ Male _ Female

3. Who do you live with?

_Alone
_Spouse
_Family
_Other

4. During the **past 2 months,** have you felt depressed, down and out or anxious?

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

5. 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.

6. During the **past 2 months**, have you experienced a loss of interest in things that would normally bring you pleasure?

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

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

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

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

____

9. During the **past 2 months**, was someone available to help you if you needed and wanted help?

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

10. 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.

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

_ Yes. _ No.

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

_ Yes. _ No.

13. Can you prepare your own meals?

_ Yes. _ No.

14. Do you have any problems eating?

_ Yes. _ No.

15. Do you have any teeth or denture problems?

_ Yes. _ No.

16. Do you wear glasses or contacts?

_Yes _ No

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

_ Yes _ No

18. Do you have any speech problems?

_ Yes _ No

19. Can you do your housework without help?

_ Yes. _ No.

20. 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.

21. Can you handle your own money without help?

_ Yes. _ No.

22. Do you have any financial concerns?

_ Yes. _ No.

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

_ Excellent.
_ Very good.
_ Good.
_ Fair.
_ Poor.

24. How have things been going for you during the **past 2 months**?

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

25. Are you having difficulties driving your car?

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

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

_ Yes, always
_ Yes, sometimes.
_ No.

27. Do you experience falling or dizziness when standing up?

_ Yes. _ No.

28. Do you use anything to help you ambulate?

_ independent
_ wheelchair
_ walker
_ cane

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

_ Yes. _ No.

If YES—WHEN? ____

Injuries _Yes _ No

30. Are you afraid of falling?

_ Yes. _ No.

31. Are you a smoker?

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

32. 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.

33. 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.

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

_ More
_ Less
_ Same

35. 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.

36. 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.

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