www.southbendclinic.com

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Granger, IN 46530	South Bend, IN 46614	South Bend, IN 46617	South Bend, IN 46628	Carlisle, IN *46552*
574-271-0700	574-299-2400	574-237-9340	574-204-6200	*574-654-8490*

MEDICARE ANNUAL WELLNESS VISIT

We are pleased to offer the Medicare free benefit called the Annual Wellness Visit. During this visit we will work with you to make a plan for how to stay well.

What is the Annual Wellness Visit?

— This visit is for talking with your healthcare team about your medical history, your risk for certain diseases, the current state of your health and your plan for staying well.
— We will measure your height, weight and blood pressure.
— We might refer you for screenings or services outside of the appointment.

How is the Annual Wellness Visit different from other visits?

— This is not the same as a yearly physical exam.
— We will not listen to your heart and lungs or check other parts of your body.
— You probably will not get screenings or blood tests during this visit.
— We would want to schedule another appointment if you are not feeling well or are concerned about a medical problem.

Who pays for it?

— Medicare will pay for the Annual Wellness Visit so you will have no out of pocket expense.
— If you receive additional tests or services during the same visit that aren't covered under these preventive benefits, you may have a co-pay and the Part B deductible may apply.

Patient Checklist and Things to Bring to Your Visit:

______ Complete all of the forms and questionnaires provided in this packet and bring them to your visit.
______ Provide a list of other physicians or health care providers who are currently treating you.
______ Provide a list of medical equipment suppliers/companies (ex. oxygen supplier).
______Provide the names and locations of the pharmacies you use (including mail order).
______ Bring a bag with all of your current medications including over-the-counter drugs, vitamins and herbals.

We look forward to working with you to make a plan to help you stay well.

Office Use Only:
Patient: __________________ MR#_______

Medicare Wellness Visit

Patient Name: ____ **Date:** ______/______/______
Date of Birth: ______/______/______ **Age**: _____ **Gender:** ☐ M ☐F

HEALTHCARE TEAM

Please list members of your current care team (Visiting Nurses, Therapies, Durable Medical Equipment Supplier, and any other Medical Clinics, physicians or advanced healthcare providers).

Eye Care Provider: ____________________ **Date of Last Exam:** ______/______/______
Dental Provider: ____________________ **Date of Last Exam:** ______/______/______
Other: ____________________
Other: ____________________
Other: ____________________

ALLERGIES TO MEDICATIONS

☐ No Allergies ☐ Allergies to Medications, *list all allergies and/or intolerances to medications & your reaction*

Medication Allergy	Reaction(s)

MEDICATIONS/VITAMINS/SUPPLEMENTS

☐ Not taking any medications ☐ Taking medications, *list all medications, vitamins & supplements including dose*

Medication	Dose (strength & quantity)	Prescribing Doctor
1.		
2.		
3.		
4.		
5.		
6		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

Continue on back page if needed….

Office Use Only:
Patient: ____________________ MR#_______

REVIEW OF SYSTESM

Check no or yes if you currently suffer from any of the following problems?

Constitutional

Tired or Fatigue	☐ No	☐ Yes
Weight gain	☐ No	☐ Yes
Weight loss	☐ No	☐ Yes

HEENT

Hearing loss	☐ No	☐ Yes
Nasal drainage	☐ No	☐ Yes
Sinus pressure	☐ No	☐ Yes
Trouble swallowing	☐ No	☐ Yes
Visual changes	☐ No	☐ Yes

Respiratory

Chronic cough	☐ No	☐ Yes
Cough	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes

Musculoskeletal

Joint Pain / Swelling	☐ No	☐ Yes
Muscle weakness	☐ No	☐ Yes

Other: ________________________

Other: ________________________

Cardiovascular

Chest pain	☐ No	☐ Yes
Leg swelling	☐ No	☐ Yes
Palpitations	☐ No	☐ Yes

Gastrointestinal

Abdominal pain	☐ No	☐ Yes
Blood in stools	☐ No	☐ Yes
Change in stools	☐ No	☐ Yes
Constipation	☐ No	☐ Yes
Diarrhea	☐ No	☐ Yes
Heartburn	☐ No	☐ Yes
Loss of appetite	☐ No	☐ Yes
Nausea	☐ No	☐ Yes

Other: ________________________

Genitourinary

Painful urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Urinary frequency	☐ No	☐ Yes
Urinary incontinence	☐ No	☐ Yes
Urinary retention	☐ No	☐ Yes

Other: ________________________

Psychiatric

Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes

Neurological

Dizziness	☐ No	☐ Yes
Numbness	☐ No	☐ Yes
Weakness	☐ No	☐ Yes
Headache	☐ No	☐ Yes
Memory Loss	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Loss of Balance	☐ No	☐ Yes

Hematologic

Easy bleeding	☐ No	☐ Yes
Easy bruising	☐ No	☐ Yes

Metabolic/Endocrine

Cold intolerance	☐ No	☐ Yes
Heat intolerance	☐ No	☐ Yes
Increased thirst	☐ No	☐ Yes
Increased appetite	☐ No	☐ Yes

***Reproductive** (Female)*

Abnormal Pap	☐ No	☐ Yes
Hot flashes	☐ No	☐ Yes
Vaginal discharge	☐ No	☐ Yes

***Reproductive** (male)*

Erectile dysfunction	☐ No	☐ Yes
Penile discharge	☐ No	☐ Yes
Sexual dysfunction	☐ No	☐ Yes

Integumentary

Hives/Rash	☐ No	☐ Yes
Mole changes	☐ No	☐ Yes
Skin lesions	☐ No	☐ Yes

SCREENING & PREVENTIVE SERVICES

Immunizations:

Influenza (Flu) Vaccine	☐ No	☐ Yes	When/Date: ________________
Prevnar 13 Vaccine	☐ No	☐ Yes	When/Date: ________________
Pneumovax Vaccine	☐ No	☐ Yes	When/Date: ________________
Hepatitis B Vaccine	☐ No	☐ Yes	When/Date: ________________

Diagnostic Screening:

Colorectal Cancer	☐ No	☐ Yes	When/Date: ________________	Abnormal? ☐ No ☐ Yes
Diabetes	☐ No	☐ Yes	When/Date: ________________	Abnormal? ☐ No ☐ Yes
Bone Density	☐ No	☐ Yes	When/Date: ________________	Abnormal? ☐ No ☐ Yes
Glaucoma	☐ No	☐ Yes	When/Date: ________________	Abnormal? ☐ No ☐ Yes
Abdominal Aortic Aneurysm	☐ No	☐ Yes	When/Date: ________________	Abnormal? ☐ No ☐ Yes

------***Women Only***--------

Mammogram	☐ No	☐ Yes	When/Date: ________________	Abnormal? ☐ No ☐ Yes
Pap Smear /Pelvic Exam	☐ No	☐ Yes	When/Date: ________________	Abnormal? ☐ No ☐ Yes

MEDICAL HISTORY

Place a Check in the box next to the following conditions you have been diagnosed with:

☐ Anemia	☐ Cholesterol	☐ Heart Disease	☐ Renal Disease
☐ Arthritis	☐ COPD	☐ Hypertension	☐ Sleep Apnea
☐ Anxiety	☐ Diabetes Type I	☐ Obesity	☐ Stroke
☐ Blood Clots	☐ Diabetes Type 2	☐ Osteoporosis	☐ Thyroid Disorder

☐ Cancer: ☐Bladder ☐Breast ☐Colon ☐Gastric ☐Lung ☐Thyroid ☐Ovarian ☐Other:_____________

☐ Other: ____

FAMILY HISTORY

Circle the letter that represents the family member: Mother (M), Father (F), Sister (S) and Brother (B)

Father: ☐ Alive & Well ☐ Deceased, Cause of Death:______________________________ Age:_____
Mother: ☐ Alive & Well ☐ Deceased, Cause of Death:______________________________ Age:_____

Allergies	M F S B	Cancer: Colon	M F S B	Heart disease	M F S B
Alzheimer's disease	M F S B	Cancer: Bladder	M F S B	Hypertension	M F S B
Arthritis	M F S B	Cancer: _____________	M F S B	Obesity	M F S B
Asthma	M F S B	Depression	M F S B	Osteoporosis	M F S B
Blood disorder	M F S B	Diabetes type:___	M F S B	Renal disease	M F S B
Cancer: Breast	M F S B	Eczema	M F S B	Stroke	M F S B

SOCIAL HISTORY

Tobacco Do you use tobacco? ☐ No/Never ☐ Yes ☐ Former - How long ago? ________ Age Quit:_____
Type/Status: ☐ Cigarette ☐ Cigar ☐ Pipe ☐ Chew ☐ Snuff ☐ Vape ☐ Other:________________
How may packs per day? ____ How many years? ____

Caffeine Do you drink caffeinated beverages ☐ No ☐ Yes, what type: _____________ Cups per day:______

Alcohol Do you drink alcohol? ☐ No ☐ Yes, what type (check all that apply): ☐ Beer ☐ Wine ☐ Liquor
Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially ☐ Occasionally ☐ Rarely

Lifestyle

Sleep: Average number of hours of sleep per night_______
Do you have trouble falling asleep: ☐ No ☐ Yes
Do you snore or has someone told you that your snore? ☐ No ☐ Yes

Exercise: Do you exercise: ☐ No ☐ Yes, what type of exercise:____________ ____________ ____________
How often do you exercise: ☐ Occasional ☐ Daily ☐ 3-4 times a week ☐ 2-3 times a week

Diet History: Do you eat a well-balanced diet, including protein, high fiber, fruits, and vegetables? ☐ No ☐ Yes
How many serving of the following do you eat each day?
Vegetables___ Fruit___ Bread___ Fried food ___
Do you eat fast food, snacks or pizza? ☐ No ☐ Yes, how often: __________
Do you drink regular soda and/or sweetened drinks? ☐ No ☐ Yes, how often ________________

Home Safety: Do you always use your seat belt in the car? ☐ No ☐ Yes
Do you have a smoke detector? ☐ No ☐ Yes

Falls: Have you fallen in the past year? ☐ No ☐ Yes, did the fall result in injury? ☐ No ☐ Yes

ADVANCED DIRECTIVES

Have you prepared a **LIVING WILL** or **ADVANCED DIRECTIVES**? ☐ No ☐ Yes

If so, is it on file with the SB Clinic or local hospital? ☐ No ☐ Yes

Do you have a Power of Attorney? ☐ No ☐ Yes, whom______________________ Relationship_______________

PATIENT HEALTH QUESTIONNAIRE (PHQ -9)

Over the last **2 weeks**, how often have you been bothered by any of the following problems? (circle the number to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Felling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Felling 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 in some way.	**0**	**1**	**2**	**3**
** Scoring to be completed by office staff* **Add Columns**		_____	+ _____	+ _____
Total:	= ________________			

10. 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**
☐	☐	☐	☐

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HEALTH ASSESSMENT QUESTIONNAIRE (HAQ-DD)

Over the last **2 weeks**, how much difficulty do you have with the following activities? (check the box)	Without **ANY** difficulty^{0}	With **SOME** difficulty^{1}	With **MUCH** difficulty^{2}	**UNABLE** to do^{3}
DRESSING & GROOMING Are you able to:				
Dress yourself, including tying shoelaces, and doing buttons?	☐	☐	☐	☐
Shampoo your hair?	☐	☐	☐	☐
ARISING Are you able to:				
Stand up from a straight chair?	☐	☐	☐	☐
Get in and out of bed?	☐	☐	☐	☐
EATING Are you able to:				
Cut your meat?	☐	☐	☐	☐
Lift a full cup or glass to your mouth?	☐	☐	☐	☐
Open a milk carton?	☐	☐	☐	☐
WALKING Are you able to:				
Walk outdoors on flat ground?	☐	☐	☐	☐
Climb up five steps?	☐	☐	☐	☐
HYGIENE Are you able to:				
Wash and dry your body?	☐	☐	☐	☐
Take a tub bath	☐	☐	☐	☐
Get on and off the toilet	☐	☐	☐	☐
REACH Are you able to:				
Reach and get down a 5-pound object (such as a bag of sugar) from just above your head?	☐	☐	☐	☐
Bend down to pick up clothing from floor?	☐	☐	☐	☐
GRIP Are you able to:				
Open car doors?	☐	☐	☐	☐
Open jars which have been previously opened?	☐	☐	☐	☐
Turn faucets on and off?	☐	☐	☐	☐
ACTIVITIES Are you able to:				
Run errands and shop?	☐	☐	☐	☐
Get in and out of a car?	☐	☐	☐	☐
Do chores such as vacuuming or yard work?	☐	☐	☐	☐

HEALTH ASSESSMENT QUESTIONNAIRE (HAQ-DD) cont.

Please check any AIDS or DEVICES that you usually use for any if these activities:

- ☐ Cane
- ☐ Walker
- ☐ Crutches
- ☐ Wheelchair
- ☐ Devices used for dressing (button hook, zipper pull, shoe horn, etc.)
- ☐ Special or built up chair
- ☐ Special or built up utensils
- ☐ Other (specify:____)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

- ☐ Dressing and Grooming
- ☐ Arising
- ☐ Eating
- ☐ Walking

Please check any AIDS or DEVICES that you usually use for any activities:

- ☐ Raised toilet seat
- ☐ Bathtub seat
- ☐ Bathtub bar
- ☐ Jar opener(for jars previously opened)
- ☐ Long-handled appliances for reach
- ☐ Long-handled appliances in bathroom
- ☐ Other (specify_________________________)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

- ☐ Hygiene
- ☐ Reach
- ☐ Gripping and opening things
- ☐ Errands and chores

We are also interested in learning whether or not you are affected by pain because of your illness.

How much pain have you had because of your illness IN THE PAST WEEK:

PLACE A VERTICAL (|) MARK ON THE LINE TO INDICATE THE SEVERITY OF PAIN

NO PAIN ____ **SEVERE PAIN**

0 **100**

DISCUSS WITH PROVIDER

Nutrition Counseling	☐ No	☐ Yes
End-of-Life Planning	☐ No	☐ Yes
Living Will	☐ No	☐ Yes
Power of Attorney for Medical Affairs	☐ No	☐ Yes

This form was completed by**:** ____ **Date:** _____/______/______

(Signature)

Relationship to Patient: ☐ Self ☐ Other: ____

(if "other" include relationship)

Relationship:____

Reviewed By: ____ **Date:** ____/______/______