ProHealth Care

To: Our Medicare Patients

Subject: Your Welcome to Medicare Exam

Medicare covers a one-time "Welcome to Medicare" visit. The "Welcome to Medicare" visit must occur during your first twelve months as a Medicare patient. This visit is only for new Medicare patients and must be performed **within the 1st year** as a Medicare patient.

The "Welcome to Medicare" visit is not the same thing as what many people often refer to as their yearly physical exam. Medicare is very specific about what the "Welcome to Medicare", appointment includes and excludes.

At the "Welcome to Medicare" visit your doctor will review your medical history, screen you for depression, and determine your functional ability and level of safety. You will be provided with a personalized prevention plan to help keep you healthy. The visit does not include a comprehensive physical exam, discussion or testing regarding any new or current medical problems, conditions or medications. You may schedule another visit to address those issues or your doctor may charge the usual Medicare fees for such services that are beyond the scope of the Welcome to Medicare visit.

We encourage you to be familiar with your insurance policy and coverage. Please refer to the following code when discussing coverage with your insurance provider

Welcome to Medicare = G0402

Please bring the following to your appointment:

- Your insurance card(s)
- Completed questionnaire enclosed with this letter
- Your prescription medication and over-the counter medication bottles including vitamins and supplements
- Immunization records
- Copies of advanced directives – forms can be found on the ProHealth Care website: http://www.prohealthcare.org/patient-guest-services-advance-directives.aspx

We look forward to seeing you. Thank you for choosing ProHealth Care for your health care needs.

Welcome to Medicare Pre-Visit Questionnaire – Male

Name _____

Date of birth _____

Please circle your answers to the questions below:

END OF LIFE PLANNING

1. Do you have a current Advance Directive, Living Will or Power of Attorney for Health Care? . . . Yes No
2. Would you like information regarding Advance Care Planning? . . . . . Yes No
3. Would you like information/assistance to create an Advance Directive? . . . . . Yes No

DIET

1. Do you eat fruit and/or vegetables every day? . . . . . Yes No
2. Do you limit your salt intake? . . . . . Yes No

PHYSICAL ACTIVITY

1. Do you usually exercise at least 30 minutes or more, 4 days a week? . . . . . Yes No

HEPATITIS, STD, HIV RISKS

1. Do you have sex with other men? . . . . . Yes No
2. Does anyone in your household have hepatitis B? . . . . . Yes No
3. Do you currently use or have you ever used intravenous drugs? . . . . . Yes No
4. Do you work in healthcare (direct patient contact)? . . . . . Yes No
5. Do you require repeated blood or blood product transfusion? . . . . . Yes No
6. Do you have liver disease? . . . . . Yes No
7. Do you have diabetes? . . . . . Yes No
8. Are you planning to spend more than 6 months, live in a rural area, or have close physical or sexual contact with the local population outside North America, Western Europe or Australia? . Yes No
9. Have you had a hepatitis B vaccination? . . . . . Yes No
10. Were you born between 1945 – 1965? . . . . . Yes No
11. Have you had a blood transfusion before 1992? . . . . . Yes No

12. Have you ever had a hepatitis C test? . . . . . Yes No

13. In the past 12 months, have you had more than one sexual partner? . . . . . Yes No

14. It is recommended that all persons under the age of 75 be screened for HIV at least once.
    Medicare covers screening for HIV/AIDs for anyone who is at risk for infection or asks to be tested.

    Would you like to be tested for HIV/AIDs . . . . . Yes No

ALCOHOL & DRUG USE

Alcohol can affect your health, medications, and treatments, so we ask patients the following questions. Your answers will remain confidential. Place an x in one box to answer. Think about your drinking in the past year. A drink means one beer, one small glass of wine (5 oz), or one mixed drink containing one shot (1.5 oz) of spirits.

1. How often do you have a drink containing alcohol?
   Never Less than monthly Monthly Weekly 2-3 times a week 4-6 times a week Daily

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   1 drink 2 drinks 3 drinks 4 drinks 5-6 drinks 7-9 drinks 10 or more drinks

3. How often do you have, on one occasion, five or more drinks (men under age 65) or four or more drinks (men 65 an over and women)?
   Never Less than monthly Monthly Weekly 2-3 times a week 4-6 times a week Daily

4. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? for example because of the experience or feeling it caused?
   0 1 2 3 4 5 6+

5. Have you or anyone in your family ever been addicted to opioids or been diagnosed with Opioid Use Disorder?
   Yes No

BOWEL/BLADDER CONTROL

1. Do you have difficulty controlling your urine or bowel movements? . . . . . Yes No

ACTIVITIES OF DAILY LIVING

1. Do you need help with Bathing . . . . . Yes No
2. Do you need help with Dressing. . . . . Yes No
3. Do you need help with Using the toilet. . . . . Yes No
4. Do you need help with Eating . . . . . Yes No

FALLS RISK

1. Do you have difficulty moving in or out of beds or chairs? . . . . . Yes No
2. Do you have difficulty with walking or balance? . . . . . Yes No

3. Have you had 2 or more falls in the last 12 months? . . . . . Yes No

HOME SAFETY

1. Have you completed a home safety evaluation? . . . . . Yes No

GLAUCOMA SCREENING

1. Do you have a family history of glaucoma? . . . . . Yes No
2. Are you over age 50 and of African-American descent? . . . . . Yes No
3. Are you over age 65 and of Hispanic-American descent? . . . . . Yes No

HEARING IMPAIRMENT

1. Do you have hearing difficulty that is not treated by a hearing aid or other assistive listening device? . . . . . Yes No

PROSTATE CANCER SCREENING

1. Are you of African-American decent? . . . . . Yes No
2. Did your grandfather, father, uncle, brother or son have prostate cancer? . . . . . Yes No

ABDOMINAL AORTIC ANEURYSM

1. Have you smoked at least 100 cigarettes in your lifetime? . . . . . Yes No
2. Do you have a family history of abdominal aortic aneurysm? . . . . . Yes No
3. Have you ever been screened for abdominal aortic aneurysm? (usually done with an abdominal ultrasound) . . . . . Yes No

DEPRESSION SCREENING

How often have you been bothered by the following symptoms during the last two weeks? Do not include symptoms that are clearly attributable to another medical condition in your responses.

1. **Little interest or pleasure in doing things?**

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

2. **Feeling down, depressed or hopeless?**

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3