ProHealth Care

To: Our Medicare Patients

Subject: Your Medicare Annual Wellness Visit

Medicare covers a Medicare Annual Wellness Visit every year. You may receive an Annual Wellness visit after you have been with Medicare for more than one year, or it has been at least one year since your "Welcome to Medicare" visit. These are covered yearly as long as it has been at least 366 days since your previous Medicare Annual Wellness Visit.

An Annual Wellness 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 Annual Wellness Visit includes and excludes.

At the Annual Wellness Visit your doctor will review your health risk assessment, your current medical providers and medical history, screen you for depression and memory loss, and determine your functional ability and level of safety. You will be provided with a personalized prevention plan to 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 fess for such services that are beyond the scope of the Medicare Annual Wellness visit.

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

First Annual Wellness visit = G0438

Subsequent Annual Wellness visit = G0439

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.

Annual Wellness Visit Pre-Visit Questionnaire – Female

Name _____

Date of birth _____

Please circle your answers to the questions below:

DEMOGRAPHIC DATA

1. What is your race?
    - American Indian or Alaska Native
    - Asian
    - Black or African American
    - Native Hawaiian or Other Pacific Islander
    - Other
    - Prefer not to answer
    - Unknown
    - White or Caucasian

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

CURRENT PROVIDERS

To assist us in having all your current health care providers on record please list your current health care providers below:

Please list you current primary care provider:

_____

Please list your current health care providers below.

_____ _____

_____ _____

_____ _____

_____ _____

Annual Wellness Visit Pre-Visit Questionnaire – Female

HEALTH STATUS

1. In general, would you say your health is:
   Excellent Very good Good Fair Poor

DIET

1. Do you eat fruit and/or vegetables every day? . . . . . Yes No
2. Do you limit your salt intake? . . . . . Yes No
3. Do you eat at least 3 dairy product servings daily or take a calcium supplement? . . . . . Yes No
4. Do you routinely eat fatty fish such as salmon or tuna or take a vitamin D supplement containing at least 800 IUs of vitamin D per day? . . . . . 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. Does anyone in your household have hepatitis B? . . . . . Yes No
2. Do you currently use or have you ever used intravenous drugs? . . . . . Yes No
3. Do you work in healthcare (direct patient contact)? . . . . . Yes No
4. Do you require repeated blood or blood product transfusion? . . . . . Yes No
5. Do you have liver disease? . . . . . Yes No
6. Do you have diabetes? . . . . . Yes No
7. 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
8. Have you had a hepatitis B vaccination? . . . . . Yes No
9. Were you born between 1945 – 1965? . . . . . Yes No
10. Have you had a blood transfusion before 1992? . . . . . Yes No
11. Have you ever had a hepatitis C test? . . . . . Yes No
12. In the past 12 months, have you had more than one sexual partner? . . . . . Yes No
13. 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

Annual Wellness Visit Pre-Visit Questionnaire – Female

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

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1. Can you travel alone by bus, taxi, or drive your own car? . . . . . Yes No
2. Can you shop for groceries or clothes without help? . . . . . Yes No
3. Can you prepare your own meals? . . . . . Yes No
4. Can you handle your own money without help? . . . . . Yes No
5. Do you have enough money to afford your medications, groceries and day-to-day bills? . . . . . Yes No
6. Can you do your own housework without help? . . . . . Yes No
7. Are you being abused or neglected? . . . . . Yes No

Annual Wellness Visit Pre-Visit Questionnaire – Female

PSYCHOSOCIAL RISKS

1. Is there someone available to help you if you needed and wanted help? . . . . . 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

VISION

1. Have you had a general eye exam within the last 2 years? . . . . . 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

ABDOMINAL AORTIC ANEURYSM

1. Do you have a family history of abdominal aortic aneurysm? . . . . . Yes No
2. 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 each of the following symptoms during the past 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