

ATTACHMENT B

Medicare Wellness Visit

Medical Record Number

Current list of patient's providers and suppliers

NAME	SPECIALTY	REASON

Family History: particularly Parents, Grandparents, Siblings, (check those that apply)

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cancer	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Obesity
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver or Kidney Disease	<input type="checkbox"/> Thyroid Disease

Additional History/Notes:

Number of servings of fruits and vegetables do you have per day? _____

How many times/week do you exercise? _____ Duration? _____ Type? _____

Hearing loss screen

- 1. Do you have trouble hearing the TV or radio when others don't? YES NO
- 2. Do you have to strain or struggle to hear/understand conversations? YES NO

Function screen

- 1. Do you need help with preparing meals, transportation, shopping, taking your meds, managing finances, or other activities of daily living? YES NO
- 2. Do you live alone? YES NO

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Fall screen

- 1. Have you had an injury from a fall in the last year? YES NO
- 2. Have you had more than one fall in the last year? YES NO

Home safety screen

- 1. Does your home have rugs, poor lighting, or a slippery bathtub/shower? YES NO
- 2. Does your home LACK grab bars in bathrooms, handrails on stairs or steps? YES NO
- 3. Does your home LACK functioning smoke alarms? YES NO

Advanced care planning

We would like to discuss your wishes and Advanced Directives with you. Please sign below if you will permit us to have this conversation.

- 1. Patient Consent: "I consent to discuss end-of-life issues with my healthcare provider."

Patient/Guardian Signature

Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" 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. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling 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 figety 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 of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card).

10. If you checked off <i>any problems</i> , 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	_____