To our Medicare patients,

APG Family Medicine Center wants you to be aware of your Medicare benefits. Medicare will cover free of charge an “Annual Wellness Visit”. This is a risk assessment visit to help prevent future medical problems. The “Annual Wellness Visit” is optional, not mandated by Medicare, but we encourage you to have this preventative risk evaluation.

At this visit we update your personal and family medical history, list of other medical providers, medication list, and immunization status. Routine measurements of blood pressure, height and weight will be taken. Depression screening, cognitive impairment, fall risk and need for assistance with activities of daily living is assessed. Lifestyle issues of substance abuse, nutrition and physical activity are reviewed. Advanced Care Planning is recommended and information will be provided on living wills and designation of a health care proxy.

A self-reported Health Risk Assessment (HRA) form is required by Medicare to be completed by patient prior to the “Annual Wellness Visit”. This can be completed at home (by downloading HRA form on the portal), or by arriving 20 minutes early for your appointment. This form is mandated by Medicare and we can not see you for an Annual Wellness Visit without it being completed.

A physical exam, management of chronic and new medical problems, medication refills, and laboratory and imaging study reviews are NOT part of an Annual Wellness Visit. These require a separate appointment. This appointment would be scheduled in addition to Annual Wellness Visit appointment and may need to be scheduled on a different day depending on appointment availability.

Thank you!

Sincerely,

APG Family Medicine Center

P.S.

Annual Wellness Visit. This visit is to address your preventive care. Per Medicare guidelines, a separate follow up visit is required to address chronic conditions and refill requests. A co-pay or co-insurance may apply.

AtlantiCare
PRIMARY CARE PLUS

Your name:_____
Date of Birth:_____/_____/_____
Today's Date:_____/_____/_____

MEDICARE WELLNESS CHECKUP

Please complete this checklist before seeing your doctor or nurse.
Your responses will help you receive the best healthcare possible.

Please list all of your Doctors/Specialists (Your Care Team)

Name	Specialty

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Name: DOB:

Health Risk Assessment Questionnaire

Are there hazards in your house that might hurt you?	No	Yes
Are you able to walk without assistance?	No	Yes
Are you worried you might fall?	No	Yes
Do you use a cane or walker?	No	Yes
Do you need someone to help you get up in the morning?	No	Yes
In the past four weeks, have you fallen or felt dizzy when standing up?	No	Yes
Have you had 2 or more falls in the past year?	No	Yes
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?	No	Yes
Do you have trouble consistently taking or remembering to take all of your medications as prescribed?	No	Yes
Is the patient currently taking opioids?	No	Yes
During the past four weeks, have you had pain present?	No	Yes

A. Primary Pain Location:

B. Numeric Rating Scale

C. Numeric Rating Pain Score

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

○ No ○ Yes

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

○ No ○ Yes

Can you prepare your own meals?

○ No ○ Yes

Can you do your housework without help?

○ No ○ Yes

Can you handle your own money without help?

○ No ○ Yes

Can you keep track of your own medications without help?

○ No ○ Yes

How have things been going for you during the past four weeks?

○ Very well ○ Good and bad parts about equal ○ Very bad
○ Pretty well ○ Pretty bad

19. During the past four weeks, how would you rate your health in general?

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

20. During the past four weeks, 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

21. During the past four weeks, 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

22. During the past four weeks, how often have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Sexual problems					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					

23. How confident are you that you can control and manage most of your health problems?

○ I do not have any health problems ○ Very confident ○ Somewhat confident ○ Not very confident

24. Are you having difficulties driving your car?

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

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

○ Always ○ Sometimes ○ Never

Hearing Screen

Do you have any hearing concerns?

○ Yes ○ No

Do you currently have hearing aids?

○ Yes ○ No

Do you have an appointment scheduled with ENT/audiologist?

○ Yes ○ No

Audiogram Result, Left Ear

Audiogram Result, Right Ear

Hearing Screen Comments

ENT/Audiologist

Vision Screen

Do you have any problems with your vision?

○ Yes ○ No

Do you follow up with yout Optometrists/ophthalmologists

○ Yes ○ No

Optometrists/Ophthalmologists

Visual Acuity, Left Eye

Visual Acuity, Right Eye

Vision Test Type

Vision Screen Comments

Home Safety Screening

Are emergency numbers kept by the phone and regularly updated?

○ Yes ○ No

Are all household members aware of the dangers of smoking, especially in bed?

○ Yes ○ No

Are working smoke alarm(s) and fire extinguisher(s) available for use?

○ Yes ○ No

Do all household members know how to use them?

○ Yes ○ No

Are firearms stored unloaded and securely locked?

○ Yes ○ No

Have throw rugs been removed or fastened down?

○ Yes ○ No

Are non-slip mats in all bathtubs and showers?

○ Yes ○ No

Do all stairways have a railing or banister?

○ Yes ○ No

Are sidewalks and all outdoor steps clear of tools, toys, and other articles?

○ Yes ○ No

Are doorways, halls, and stairs free of clutter?

○ Yes ○ No

Are all electrical cords in working order, easily seen, and not run under rugs/carpets or wrapped around nails?

○ Yes ○ No

Comments