Piedmont HealthCare

Nabors Family Medicine

We are pleased to work with Medicare and offer a ***free*** benefit called the Annual Wellness Visit. During this visit we will work with you together to help you stay healthy.

What is the Annual Wellness Visit?

- This visit is for talking with your healthcare provider about your medical history, risks for certain diseases, current state of your health and to develop a plan for staying well.
- We will measure your height, weight and pertinent vitals.
- We make refer you for necessary 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, this is considered a "no touch" exam.

What if I am ill or have urgent concerns about a medical problem?

- If you are not feeling well or you are concerned about a medical problem during your upcoming appointment, please notify us during check in.
- *Billing Note: A "sick visit" cannot be combined with your "annual wellness visit". If you choose to have the two visits on the same day, you may have a co-pay and Part B deductible may apply.*

When do I get it?

- You can receive a Wellness Visit ("Welcome to Medicare") during the first 12 months you are enrolled in Medicare Part B.
- You can then schedule a Wellness Visit once a year.

Who pays for it?

- Medicare will pay for the Annual Wellness Visit so you will have no out of pocket expense.
- You might have a copayment for some screening services and follow up visits.
- 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.

Things to bring to your Annual Wellness Visit:

- A list of all your healthcare team including any specialists.
- The names of your home health agency and medical equipment supply companies (ex. oxygen supplier).
- An accurate list of the medicines you take including over-the-counter drugs, vitamins and herbals.
- The Wellness Packet completed if received via mail or at your visit

We look forward to working with you to help you stay healthy!

Your Appointment is scheduled for: _____

Medicare Annual Wellness Visit:
____Welcome to Medicare ____Initial _____Subsequent

Dr. Emily Nabors

Piedmont HealthCare

Patient Name: Date of Birth:

Personal Medical History: *Please indicate whether you have had any of the following medical problems (past or present):*

	Past	Current
Anemia	☐	☐
Arthritis	☐	☐
Anxiety	☐	☐
Blood Clots	☐	☐
COPD	☐	☐
Diabetes Type: _____		

	Past	Current
Heart Disease	☐	☐
High Cholesterol	☐	☐
Hypertension	☐	☐
Obesity	☐	☐
Osteoporosis	☐	☐
Renal Disease	☐	☐

	Past	Current
Sleep Apnea	☐	☐
Stroke	☐	☐
Thyroid	☐	☐
Cancer(type):	☐	☐
Other:	☐	☐

1.) Have you have any falls in the last year?
☐ No ☐ Yes How many? _____

2.) Do you have any problems with bladder leakage (even a small amount)? ☐ No ☐ Yes 0

3.) Do you feel you are at a high risk of contracting sexually transmitted diseases or HIV?
☐ Yes ☐ No

4.) Please check the items below if you need any assistance with these functions?
☐ Using the telephone ☐ Housework
☐ Preparing meals ☐ Laundry
☐ Managing Medications ☐ Dressing
☐ Handling Finances ☐ Walking
☐ Bathing ☐ Shopping
☐ Driving (*or finding transportation*)

5.) Do you follow any of the following specific diets?
☐ Diabetic ☐ High Fiber ☐ None ☐ Low Fat
☐ Low Sodium ☐ Low Carb ☐ Low Calorie
☐ Low Cholesterol

6.) Do you have any social or financial concerns? Fear of abuse, safety, lack of family support, worried about paying your bills, pay for food or medicine? ☐ Yes ☐ No

7.) In the past year, have you been hospitalized?
☐ No ☐ Yes how many times____when_____?

8.) Have you noticed any hearing problems? ☐ No ☐ Yes

What is your overall pain level in day to day life?
0 1 2 3 4 5 6 7 8 9 10

9.) Do you use any of the following for assistance with mobility?
☐ Independent ☐ Cane ☐ Walker ☐Bedbound ☐ Other

10.) Do you have any of the following concerns? ☐ None ☐ Oral Health/Dental Care ☐ Exposure Secondhand ☐ Smoke Risky Sexual Behaviors ☐Performs Self Breast ☐ Takes Multivitamin Exam

11.) What is your physical activity compared to last year?
☐ Same ☐ Less ☐ More

12.) Have rugs and other hazards been removed for safety in your home? ☐ Yes ☐ No

13.) Do you have adequate lighting? ☐ Yes ☐ No

14.) Do you have grab bars in your bathroom? ☐ Yes ☐ No

Social History: Do you smoke? ☐ Yes ☐ No If so, how many packs a day _____ How many years _____
Do you consume alcoholic beverages? ☐ Yes ☐ No If so, how much a month _____
Do you take recreational drugs? ☐ Yes ☐ No If so, frequency _____

Family History: *Please indicate if any person in your immediate family had any of the following:*

Family Member: M: Mother, F: Father, B: Brother, S: Sister, G: Grandparent, C: Child

	M	F	B	S	G	C
☐ Allergies						
☐ Alzheimer's Disease						
☐ Arthritis						
☐ Asthma						
☐ Cancer: Type						

	M	F	B	S	G	C
☐ Depression						
☐ Diabetes Type __						
☐ Excema						
☐ Heart Disease						
☐ Hypertension						
☐ Obesity						

	M	F	B	S	G	C
☐ Osteoporosis						
☐ Renal Disease						
☐ Stroke						
☐ Thyroid						
☐ Other:						

Patient Name: _____ Date of Birth: _____

Surgical History

Procedure	Date	Facility / Surgeon

Screening & Preventative Services

Prevnar 13 Vaccine	☐ No ☐ Yes	Date: _____	Tetanus	☐ No ☐ Yes	Date: _____
Pneumovax Vaccine	☐ No ☐ Yes	Date: _____	Influenza (Flu) Vaccine	☐ No ☐ Yes	Date: _____
Hepatitis B Vaccine	☐ No ☐ Yes	Date: _____	Other: _____	Date: _____	
Shingles	☐ No ☐ Yes	Date: _____	Other: _____	Date: _____	

Diagnostic Screening

Colorectal Cancer	☐ No ☐ Yes When/Date: _____	Abnormal? ☐ No ☐ Yes	
Bone Density	☐ No ☐ Yes When/Date: _____	Abnormal? ☐ No ☐ Yes	
Glaucoma	☐ No ☐ Yes When/Date: _____	Abnormal? ☐ No ☐ Yes	
Prostate	☐ No ☐ Yes When/Date: _____	Abnormal? ☐ No ☐ Yes	
Low Dose CT	☐ No ☐ Yes When/Date: _____	Abnormal? ☐ No ☐ Yes	
Diabetic Exams	Retinal Eye Exam ☐ No ☐ Yes When/Date: _____	Abnormal? ☐ No ☐ Yes	
	Foot Exam ☐ No ☐ Yes When/Date: _____	Abnormal? ☐ No ☐ Yes	
Mammogram	☐ No ☐ Yes When/Date: _____	Abnormal? ☐ No ☐ Yes	
Pap Smear /Pelvic Exam	☐ No ☐ Yes When/Date: _____	Abnormal? ☐ No ☐ Yes	

Allergies / Interaction

Medication/Substance/Item	Reaction

Medications/Vitamins/Supplements/Non-Prescriptions

Medication Name /Strength / Frequency	Medication Name /Strength / Frequency

HealthCare Team

Please list members of your current care team (health care providers and / or clinics

Eye Care Provider: _____ Date of Last Exam: ____/____/____

Dental Provider: _____ Date of Last Exam: ____/____/____

Other: _____ Specialty: _____

Other: _____ Specialty: _____

13.) Do you have a living will or any advanced directives? ☐ Yes ☐ No

Is there a copy in your chart? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Patient Health Questionnaire – 2/9
PHQ2/9

A part of routine screening for your health includes reviewing mood and emotional concerns.

During the past two weeks, have you been bothered by the following problems?		
Feeling down, depressed, irritable, or hopeless .	☐ Yes	☐ No
Little interest or pleasure in doing things .	☐ Yes	☐ No

If you answered "YES" to either question above please answer all questions below.

<u>During The Past Two Weeks</u>, how often have you been bothered by the following problems?	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
Feeling down, depressed, irritable, or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss, or overeating				
Feeling tired or having little energy				
Feeling bad about yourself – or feeling that you are a failure, or have let yourself or your family down				
Trouble concentrating on things, like reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite –being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you are experiencing any of the problems on this form, 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*

For Office Use Only: **Total Score** ☐