Primary Care Specialists, P.C.

Elise Murray, D.O.
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(734) 641-8900
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Your Annual Medicare Wellness Visit

Preventative medicine, that is medicine and services that help you from being sick or help you manage your current conditions so that they don't get worse, is one of the most important things you can do to add longevity to your life. Your wellness visit is an opportunity for you and your doctor to discuss your general health during a time when you are not in for a sick visit or chronic care visit and therefore not focused on how you are feeling at the moment.

What to expect:

You should be asked to fill out a questionnaire to help your doctor assess your current state of health prior to your visit. The doctor will review your answers to determine what your health risks are. This will become part of your Personalized Prevention Plan.

Your **height** and **weight** will be measured and your **BMI** (Body Mass Index) will be calculated. Your **blood pressure** will also be taken. This gives the doctor a quick picture of your current health and possible future risk.

Your **family, medical,** and **social history** will be updated to determine if you are at a greater than average risk for certain diseases.

Your **medications** will be reviewed to be sure that there are no drug interactions with each other and that you are not taking any that you no longer need.

The list of **doctors** you are currently seeing will be reviewed. Knowing who you are seeing and for what health issues, allows us to better coordinate your care and contact the right doctor if needed.

You will leave with a personalized list of **recommended preventative services** giving the date you last had the service done and when you are due to have it repeated. You will also be given a list of your health risks and what your doctor wants you to do to prevent, manage, or reduce future health concerns.

After your visit, plan to have an open and honest discussion with your family. You should share with them your current health status, current risks, and additional screenings that are recommended. This is an opportunity to discuss what you want done in case of an emergency. Knowing what you would like done, or not done, when it comes to important health decisions is good for your family, your doctor, and you.

NOTE: this visit is not intended to be a physical examination or a visit to discuss chronic or acute symptoms you may be having. Please schedule an appointment for another time for these purposes.

Patient Name: _____________________ Date of Birth:___________ Date:_______

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Wellness Exam Questionnaire

Patient Name: Date of Birth:

Today's Date:

Instructions: Please **circle** your answers.

Question		
Are you able to hear normal conversational voice?	Yes	No
Do you have, and use hearing aids?	Yes	No
Do you have difficulty driving, watching TV, or reading because of poor eyesight?	Yes	No
Have you intentionally lost weight in the last 6 months?	Yes	No
Do you have difficulty eating because of missing teeth or ill-fitting dentures?	Yes	No
Have you ever lost urine or gotten wet?	Yes	No
Do you have trouble controlling your bowels?	Yes	No
Do you feel secure walking without help?	Yes	No
Do you use a cane, walker, or wheelchair?	Yes	No
How many falls have you had in the last year? ____________		
Do you often feel sad or depressed?	Yes	No
Do you have an Advanced Directive?	Yes	No

Patient Name: ____________________ Date of Birth:___________ Date:_______

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Activities of daily living:

Are you (I) **Independent** requiring no help, (A) Need some help or **Assistance**, or (D) Cannot do at all, **Dependent** with the following tasks:

Walking	I A D	Using the telephone	I A D
Dressing	I A D	Shopping	I A D
Bathing	I A D	Preparing meals	I A D
Eating	I A D	House work/laundry	I A D
Toileting	I A D	Managing Finances	I A D
Driving	I A D	Taking Medications	I A D

What is your favorite leisure activity? ________________________________

Do you find yourself avoiding this activity because it's difficult? Yes No

Do you live with anyone? Yes No

If yes, who? Spouse Child Relative Friend

Who would make health care decisions for you if you are not able?

____

List all medications, prescription and over the counter, that you are taking.

____________________ ____________________ ____________________

____________________ ____________________ ____________________

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What is your system for organizing and taking your medications?

Pillbox Family help List or Chart None

List any other doctors you have seen in the last 12 months and the reason you are seeing them.

Doctor	Condition/Reason
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

List any Surgeries or Procedures you have had in the last two years.

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

Smoking History

# of years smoked______ What did/do you smoke?_______________________

Quit Year________ How many packs or cigarettes per day?_________________

Patient First & Last Name: ______________________

Patient Date of Birth: ______________________

Patient Primary Care Physician: ______________________

Assessment for Social Needs

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Today's Date: ______________________

As your Patient-Centered Medical Home, we are happy to partner with you, to help you and your family in times of need. From the answers below, we maintain a list of trusted community resources that care about you as much as we do.

Please Answer the following questions:	Yes	No	Decline to Answer
In the past month, did poor health keep you from doing your usual activities, like work, school, or a hobby?	☐	☐	☐
In the past 12 months, was there a time when you needed to see a doctor but could not because it cost too much?	☐	☐	☐
In the past 12 months, did you ever eat less than you needed to because there was not enough food?	☐	☐	☐
Is it hard to find work or another source of income to meet your basic needs?	☐	☐	☐
Are you worried that in the next 2 months, you may not have housing?	☐	☐	☐
In the past 12 months, have you had a hard time paying your utility company bills?	☐	☐	☐
Do you need help finding or paying for care for loved ones? For example, childcare or day care for an older adult.	☐	☐	☐
Do you want help with school or job training, like finishing a GED, going to college, or learning a trade?	☐	☐	☐
In the past 12 months, have you had trouble getting to school, work, or the store because you do not have a way to get there?	☐	☐	☐
Do you ever feel unsafe in your home or neighborhood?	☐	☐	☐
Over the last 2 weeks, have you had a great deal of stress or felt overwhelmed?	☐	☐	☐
Over the last 2 weeks, have you felt a lot of anxiety or scared?	☐	☐	☐
Over the last 2 weeks, have you felt depressed or very sad?	☐	☐	☐
*If you answered yes, would you like to receive assistance with any of these needs?	☐	☐	☐
*Are any of your needs urgent? For example, I need food/shelter for tonight.	☐	☐	☐

FOR OFFICE STAFF ONLY: **PRIMARY INSURANCE, MEMBER ID**______________________

Is patient being provided care management or care coordination services?			

Referrals	Due Date/Follow-Up
1.	
2.	

Patient Health Questionnaire (PHQ-9)

Patient Name:____ Date:______________

	Not at all	Several days	More than half the days	Nearly every day
1. Over the last 2 weeks how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.				
i. Thoughts that you would be better off dead or of hurting yourself in some way.				
THIS ROW FOR DOCTOR'S USE ONLY SCORE:	0	1	2	3
(add columns)		+	+	+
TOTAL SCORE:	=			
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, 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?				