Carrboro Pediatrics & Internal Medicine

Instructions for the Medicare Annual Wellness Visit

The Medicare Annual Wellness Visit is a benefit to Medicare recipients which allows you to discuss and update your preventive health care screening needs and go over issues which affect your current health. According to Medicare, this does not include the physical exam part of the visit. We wanted to make sure that you are aware of this. If time allows, the doctors may be able to cover part or all of your physical exam.

1. Please print and fill out the Health Habits and Activities of Daily Living Questionnaire.

2. Please fill out the top portion of the Medical Annual Wellness Visit summary sheet. This will help us keep track of the other doctors and providers that you see regularly and any equipment suppliers. You do not need to fill in the Preventive Services Checklist. We will do this during your visit.

3. Please bring all your medication bottles, including over the counter medications, to your visit so we can make sure that our records reflect what you are actually taking.

Carrboro Pediatrics & Internal Medicine, P.A.
MEDICARE ANNUAL WELLNESS VISIT

Name:_____ Date: _____

List of providers seen in the last year:

Name of Physician/Provider	Field of Specialty

List of medical suppliers (CPAP/respiratory supplies, oxygen, home health, diabetic supplies, wheelchairs or hospital beds, etc.) used in the last year:

Type of Equipment	Name of Supplier

Preventive Services Checklist	Date Patient Had this Test/Screening/Service	Due Date for Next Test/Screening/Service
AAA Screening		
Bone Mass Measurement		
CV Screening Blood Tests		
Colorectal Cancer Screen		
Diabetes Screening Test		
Glaucoma Screening		
HIV Screening		
Mammogram		
Med Nutrition (DM, CKD)		
Pap/Pelvic/Breast		
Prostate Cancer Screening		
Shots- Flu, Pvx, HepB, Zvx		
Smoking Cessation		

AAA- Men ages 65-75 with any history of smoking, FH of AAA (men and women)
Pap/Pelvic- Every 24 months, annual if high risk
Mammogram- Annually
PSA- Annually
Bone Density- Every 24 months
CV Lipids- Every 5 years if just screening
DM Screening- Yearly, twice yearly if have pre-diabetes
Glaucoma screening- Annually

Name_____

Date_____

Physical Activity

In the past 7 days, how many days did you exercise?

_____ days

On days when you exercised, for how long did you exercise (in minutes)?

_____ minutes per day

- ❒ Does not apply

How intense was your typical exercise?

- ❒ Light (like stretching or slow walking)
- ❒ Moderate (like brisk walking)
- ❒ Heavy (like jogging or swimming)
- ❒ Very heavy (like fast running or stair climbing)
- ❒ I am currently not exercising

Tobacco Use

In the last 30 days, have you used tobacco?

Smoked:

- ❒ Yes
- ❒ No

Used a smokeless tobacco product:

- ❒ Yes
- ❒ No

If Yes to either,

Would you be interested in quitting tobacco use within the next month?

- ❒ Yes
- ❒ No

Alcohol Use

In the past 7 days, on how many days did you drink alcohol?

_____ days

On days when you drank alcohol, how often did you have ___ (5 or more for men, 4 or more for women and those men and women 65 years old or over)) alcoholic drinks on one occasion?

- ❒ Never
- ❒ Once during the week
- ❒ 2–3 times during the week
- ❒ More than 3 times during the week

Do you ever drive after drinking, or ride with a driver who has been drinking?

- ❒ Yes
- ❒ No

Nutrition

In the past 7 days, how many servings of fruits and vegetables did you typically eat each day?
(1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)

_____ servings per day

In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day?
(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)

_____ servings per day

In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)

_____ servings per day

In the past 7 days, how many *sugar-sweetened* (not diet) beverages did you typically consume *each day*?

_____ sugar sweetened beverages consumed per day

Seat Belt Use

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

- ❒ Yes
- ❒ No

Depression

In the past 2 weeks, how often have you felt down, depressed, or hopeless?

- ❒ Almost all of the time
- ❒ Most of the time
- ❒ Some of the time
- ❒ Almost never

In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

- ❒ Almost all of the time
- ❒ Most of the time
- ❒ Some of the time
- ❒ Almost never

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?

- ❒ Yes
- ❒ No

Anxiety

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

- ❒ Almost all of the time
- ❒ Most of the time
- ❒ Some of the time
- ❒ Almost never

In the past 2 weeks, how often were you not able to stop worrying or control your worrying?

- ❒ Almost all of the time
- ❒ Most of the time
- ❒ Some of the time
- ❒ Almost never

High Stress

How often is stress a problem for you in handling such things as:

–Your health?

–Your finances?

–Your family or social relationships?

–Your work?

- ❒ Never or rarely
- ❒ Sometimes
- ❒ Often
- ❒ Always

Social/Emotional Support

How often do you get the social and emotional support you need:

- ❒ Always
- ❒ Usually
- ❒ Sometimes
- ❒ Rarely
- ❒ Never

Pain

In the past 7 days, how much pain have you felt?

- ❒ None
- ❒ Some
- ❒ A lot

General Health

In general, would you say your health is

- ❒ Excellent
- ❒ Very good
- ❒ Good
- ❒ Fair
- ❒ Poor

How would you describe the condition of your mouth and teeth—including false teeth or dentures?

- ❒ Excellent
- ❒ Very good
- ❒ Good
- ❒ Fair
- ❒ Poor

Activities of Daily Living

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

- ❒ Yes
- ❒ No

Instrumental Activities of Daily Living

In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

- ❒ Yes
- ❒ No

Sleep

Each night, how many hours of sleep do you usually get?

____ hours

Do you snore or has anyone told you that you snore?

- ❒ Yes
- ❒ No

In the past 7 days, how often have you felt sleepy during the daytime?

- ❒ Always
- ❒ Usually
- ❒ Sometimes
- ❒ Rarely
- ❒ Never