Grove Medical Associates
250 Hampton Street
Auburn, MA 01501
(508)-753-2060

Provider: _____

DOB:___ /___/___

First Name, Last Name: _____
Mailing Address: _____
Mailing Address Line 2: _____

Beginning January 1, 2011, Medicare covers an “Annual Wellness Visit” in addition to the one-time “Welcome to Medicare” exam. The “Welcome to Medicare” exam occurs only once during your first twelve months as a Medicare patient. You may receive your Annual Wellness Visit after you have been with Medicare for more than one year, or it has been at least one year since your “Welcome to Medicare” exam.

Initial Preventative Physical Exam (IPPE)	“Welcome to Medicare” is only for ***new*** Medicare patients. This must be ***done in the 1st year*** as a Medicare patient.
Annual Wellness Visit, Initial	At least 1 year after the “Welcome to Medicare” exam.
Annual Wellness Visit, Subsequent	Once a year (more than 1 year and 1 day after the last Wellness Visit).

Medicare and Medicare Advantage Plans offer an Annual Wellness Visit once a year. At the Annual Wellness Visit your provider will discuss your medical history, review your risk factors, and make a personalized prevention plan to keep you healthy. Enclosed you will find a wellness health risk assessment form. We ask that you complete this and bring it to your appointment. This will assist your provider in making personalized recommendations for your health.

At the time of the Annual Wellness visit your provider will include an evaluation of your ongoing medical problems, conditions and medications.

Although the Annual Wellness Exam is not an Annual Physical many patients have Annual Physical Exam coverage through their secondary or supplemental Medicare insurance plan. Please contact your insurance to inquire about coverage for an Annual Physical Exam.

We appreciate the trust you put in us to take care of your health care needs and hope that you will take advantage of this benefit and partner with your provider to create your personalized prevention plan.

Attached you will find three forms. Please complete the first two forms prior to your upcoming appointment. The third form is for your provider to complete. Thank you and we look forward to serving you.

MEDICARE WELLNESS VISIT PATIENT HEALTH RISK ASSESSMENT QUESTIONNAIRE (Pg 1)

Name of Patient:_____DOB:_____

Today's Date: _____

Do you have any health concerns or NEW complaints you would like to address today? Yes ___ No ___

Past Medical/Surgical History: (List illnesses, injuries, operations, hospitalizations, date and hospital)

Please list your current healthcare providers involved in your care and condition treated: (Specialists, Therapists, VNA, etc)

Are there any preventative tests you have done recently? (Lab tests, Mammograms, X-rays, etc.)

Have you had any recent immunizations? Yes__ No __

Do you have a Health Care Proxy? Yes__ No __

General Health and Social/Emotional Support:

In general, would you say your health is: Excellent ____Very Good ____ Good ____ Fair ____ Poor _____

Does handling such things as your health, finances, family, social relationships or work cause you stress?	Yes__No __
Do you get the social and emotional support you need?	Yes__No __
Do you snore or has anyone told you that you snore?	Yes__No __
Do you always fasten your seatbelt when you are in a car?	Yes__No __

Hearing Loss Screen:

Do you have trouble hearing the television or radio when others do not?	Yes__No __
Do you have to strain or struggle to hear/understand conversations?	Yes__No __

Function Screen:

Do you live alone?	Yes ___ No ___
Do you need help to shop?	Yes ___ No ___
Do you need help to do light housework?	Yes ___ No ___
Do you need help to walk across a room?	Yes ___ No ___
Do you need help to take a bath/shower?	Yes ___ No ___
Do you need help to manage the household finances?	Yes ___ No ___

Do you need help to take your medications? Yes ___ No ___

Do you feel you have trouble with memory? *** Yes ___ No ___

Home Safety Screen:

Does your home have throw rugs, poor lighting, or a slippery bathtub/shower? Yes ___ No ___

Does your home have grab bars in the bathroom, handrails on the steps or stairs? Yes ___ No ___

Does your home have functioning smoke alarms? Yes ___ No ___

MEDICARE WELLNESS VISIT PATIENT HEALTH RISK ASSESSMENT QUESTIONNAIRE (Pg 2)

Name of Patient: _____ DOB: _____
Today's Date: _____

Fall Risk Assessment:

Do you use assistive devices at home? Yes__ No __

Advanced Care Planning:

Does the patient consent to discuss end-of-life issues with healthcare provider? Yes__ No __

Has the patient already executed an advanced directive? Yes__ No __

Social History

Do you use tobacco? Yes__ No __
Date you began smoking? _____

Have you smoked 100 cigarettes in your lifetime? Yes__ No __
If you are a former smoker, date you stopped smoking? _____

Sexual History: (optional)

Have you had sex in the past 12 months? Yes ___ No ___

Have you had multiple partners? Yes ___ No ___

Have you used protection? Yes ___ No ___

Have you ever had an STD? Yes ___ No ___

Alcohol Use:

Did you have a drink containing alcohol in the past year? Yes __ No ___

If yes, how often did you have a drink containing alcohol in the past year? Answer:

If yes, how many drinks did you have on a typical day when you were drinking in the past year?

If yes, how often did you have six or more drinks on one occasion in past year?

Depression Screen:

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use x to indicate your answer): 0 = Not at all 1=Several Days 2=More than half the days 3=Nearly every day

Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
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	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead, or of hurting yourself in some way	**0**	**1**	**2**	**3**

Form Completed by:

Signature **Relationship**

MEDICARE PREVENTATIVE SERVICES CHECKLIST

Talk with your doctor or other health care provider about which of these services are right for you. As part of your yearly "Wellness" visit, you may be asked to fill out a Health Risk Assessment to help you figure out what to work on to stay healthy. To learn more, visit www.medicare.gov.

Medicare-Covered Preventative Service	**I need (Yes/No)**	**Date Last Received**	**Next Date Medicare Covers This Service**
"Welcome to Medicare": Preventative Visit (one-time) within first 12 months you have Medicare Part B			
Yearly "Wellness" Visit – 12 months after "Welcome to Medicare" visit or Part B effective date			
Abdominal Aortic Aneurysm Screening			
Bone Mass Measurement (Bone Density Test)			
Breast Cancer Screening (mammogram)			
Cardiovascular Screenings (cholesterol, lipids, triglycerides)			
Cervical and Vaginal Screenings			
Colorectal Cancer Screening			

Diabetes Screening			
Diabetes Self-Management Training			
Flu Shot			
Glaucoma Test			
Hepatitis B Shot			
HIV Screening			
Medication Nutrition Therapy Services			
Pneumococcal Shot			
Prostate Cancer			
Shingles Vaccine			
Tetanus Vaccine			
Tobacco Use Cessation Counseling			

For some services, you will need to wait a certain amount of time before getting the service again.
See page 27 of the Your Guide to Medicare's Preventative Services for more information