

Annual Medicare Wellness Visit-Patient Information

Do you have a personal Health Goal for this year?

Have you had any changes to your medical history since your last visit? Any recent surgeries?

Please review the attached Medication list and draw a line through anything you are not taking.

Are you taking any new medications? Y N **If yes, please list:**

Any new allergies: Y N

Do you smoke? Y N Have you ever smoked? Y N How much did/do you smoke a day? For how many years? Quit Date:

Are there other family members that live in your home? Y N

Do you have people in your community that you can reach out to for help if you need it? Y N

What community activities are you involved in?

Is there anything that prevents you from doing community activities? Y N

How would you rate your overall health in the past 4 weeks?

Excellent Good Fair Poor

Have you had any falls in the last 6 months? Y N

Are there things in your home that you might trip on? Y N

Do you feel safe in your home? Y N

Do you have grab bars and railings in your home? Y N

Do you or any family members have concerns about your memory? Y N

Do you participate in regular exercise? Y N

How would you describe your diet? ___Healthy ___Needs improvement

Do finances get in the way of you eating a healthy diet? ___Y ___N

Do you have a Health Care Proxy? ___Y ___N

Do you use any assistive devices?

For Mobility (cane, walker, wheelchair) ___Y ___N

For hearing (hearing aids) ___Y ___N

For Vision (glasses) ___Y ___N

Do you want an assessment for your vision, hearing or mobility? ___Y ___N

Do you need help with any of the following activities? (please check, if yes):

___Bathing/Dressing

___Shopping/cooking

___Using the bathroom

___Transportation

___Laundry/cleaning your home

___Technology (computer/cell phone)

___Medications (getting prescriptions or remembering to take them)

___home finances

Do you have problems sleeping? ___Y ___N

Is stress a problem in your life on a regular basis? ___Y ___N

Do you have any concerns about incontinence or about your urination or bowels?

___Y ___N

Do you need to wear a pad daily? ___Y ___N

Is there anything else you would like to discuss today? ___Y___N

Recommended Screening and Preventative Services:

Vaccines: Please get the following vaccines from your local pharmacy:

Yearly: Covid, Flu

Once: RSV, Pneumococcal

Tetanus/Whooping Cough: Due _____

Colorectal Cancer Screening: (45-75)

- Stool kit:
- Colonoscopy:
- No further testing recommended

Breast Cancer Screening: (40-75)

- No further testing recommended
- Due:

Osteoporosis Screening/Bone Density: (starting age 65)

- Screening recommended and ordered
- Screening not recommended

Prostate Cancer Screening (50-69)

- Screening Recommended and PSA ordered (every 2 years)
- No further screening recommended

Lung Cancer Screening (50-80)

- Not needed low risk
- No longer recommended
- Screening Recommended

Aneurysm Screening:

- One time Screening Recommended for men 65 years of age-smoker/former smoker

Cervical Cancer Screening:

- No longer needed
- Screening Recommended

Lab Screening based on personal risk:

- Screening Recommended
- Not needed low risk

Hearing Evaluation:

Please schedule

Vision Evaluation:

Recommended every 2 years

Advanced Care Planning Visit Recommended for:

- Health Care Proxy Discussion with your PCP
- MOLST/POLST
- Durable power of Attorney (with your lawyer)
- MOCA baseline memory testing
- Consult with Geriatric specialist, Dr Finke.

Community Resources to Consider:

- Meals on Wheels
- Home Health Aid
- Transportation
- Senior Center-Exercise
- Emergency Call Button