ROGUE RIVER
FAMILY PRACTICE CLINIC

509 E. Main Street
Rogue River, Oregon 97537
www.rogueriverfpc.com
541-582-0505

TO OUR
MEDICARE PATIENTS

Dear Patient,

Medicare will be billed for your annual wellness exam, but if you are seen for additional services, you may incur additional charges.

Thank you

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A WORD TO OUR PATIENTS ABOUT
MEDICARE AND WELLNESS CARE

Dear Patient,

We want you to receive wellness care – health care that may lower your risk of illness or injury. Medicare pays for most wellness care, but it does not pay for all the wellness care you might need. We want you to know about your Medicare benefits and how we can help you get the most from them.

The term "physical" is often used to describe wellness care. But Medicare does not pay for a traditional, head-to-toe physical. Medicare does pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:

- **Screenings** to detect depression, risk for falling and other problems,
- **A limited physical exam** to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- **Recommendations** for other wellness services and healthy lifestyle changes,
- **Discuss Medicare-covered services** that allow our care team to more closely monitor your health conditions and update your plan of care before office visits.

Before your appointment, our staff will ask you some questions about your health and may ask you to fill out a form to help identify your health risks.

A wellness visit does not deal with new or existing health problems. That would be a separate service and requires a longer appointment. Please let our scheduling staff know if you need the doctor's help with a health problem, a medication refill or something else. We may need to schedule a separate appointment to address problems. **A separate charge applies to these services, whether provided on the same date or a different date than the wellness visit**.

We hope to help you get the most from your Medicare wellness benefits. Please contact us with any questions. **541-582-0505**.

Thank you

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MEDICARE ANNUAL WELLNESS VISIT
HEALTH RISK ASSESSMENT

Patient Name_____ DOB_____ Date_____

PERSONAL INFORMATION	
What is your primary language spoken at home?	☐ English ☐ Spanish ☐ Other: _____
How do you prefer we communicate?	Phone/Text: _____ E-mail: _____
Do you use a local pharmacy?	☐ Yes ☐ No Name: _____ Phone Number: _____

GENERAL HEALTH	
How is your overall health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
How confident are you that you can manage most of your health problems?	☐ Confident ☐ Somewhat ☐ Not very confident ☐ Don't have any health concerns
What are your biggest concerns about managing your health? *(Check all that apply)*	☐ None ☐ I live in an unsafe environment ☐ Transportation to appointments ☐ Financial difficulty in paying for services/medicines ☐ I have difficulty taking my medicines ☐ Difficult reading or understanding instructions ☐ I am lonely or don't have a lot of support at home ☐ I fall a lot at home
How many times in the last 6 months have you been to the emergency room?	☐ 0 ☐ 1 – 2 ☐ 3 – 4 ☐ 5+ ☐ I don't know
How many times in the last 6 months have you been admitted to the hospital?	☐ 0 ☐ 1 – 2 ☐ 3 – 4 ☐ 5+ ☐ I don't know
Please list any new healthcare providers you have seen since your last visit with us.	
How many different prescriptions are you taking?	☐ 0 – 3 ☐ 4 – 6 ☐ 7 – 10 ☐ 10+ ☐ I don't know
Please list any new medicines you have started since your last visit with us.	
Have you had any problems with your vision?	☐ Yes ☐ No
Have you had any problems with your hearing?	☐ Yes ☐ No
Do you or your family members have any concerns about your memory?	☐ Yes ☐ No

Please list any updates to your Family Medical History *(family conditions that your doctor may not know about)*:	☐ Yes ☐ No

TOBACCO & ALCOHOL USE	
Do you use any tobacco products? *(Cigarettes, chew, snuff, pipes, cigars)*	☐ Yes ☐ No
If so, are you interested in quitting tobacco?	☐ Yes ☐ No ☐ I don't use tobacco
How many times in the past year have you had 4 or more drinks in a day?	☐ 1 – 2 ☐ 3 – 4 ☐ 5+ ☐ I don't drink

NUTRITION	
Do you follow any special diet? *(low sodium/ cholesterol/fat?)*	☐ Yes ☐ No
Do you use any dietary supplements, including meal replacement drinks?	☐ Yes ☐ No
In the past 7 days, how many sugar-sweetened *(not diet)* beverages did you typically consume each day?	☐ 1 – 2 ☐ 3 – 4 ☐ 5+ ☐ I don't know

PHYSICAL ACTIVITY	
How many days a week do you exercise?	☐ 1 – 2 ☐ 3 – 4 ☐ 5+ ☐ I don't know
How intense is your exercise?	☐ Light ☐ Moderate ☐ Heavy ☐ Very heavy ☐ I don't know ☐ I don't exercise

SLEEP	
How many hours of sleep do you usually get?	☐ 0 – 3 ☐ 4 – 6 ☐ 7 – 10 ☐ I don't know
Do you snore, or has anyone told you that you snore?	☐ Yes ☐ No ☐ I don't know
In the past 7 days, how often have you felt sleepy during the day?	☐ Often ☐ Sometimes ☐ Almost never ☐ Never
Have you ever been diagnosed with Sleep Apnea or other sleep disorders?	☐ Yes ☐ No ☐ I don't know
Are you currently using or have you used C-PAP/Bi-PAP?	☐ Yes ☐ No

DEPRESSION PHQ-2

In the past 2 weeks, how often have you been bothered by the following problems:	**Not at all:**	**Several Days:**	**More than half of those days:**	**Nearly every day:**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Total Score:

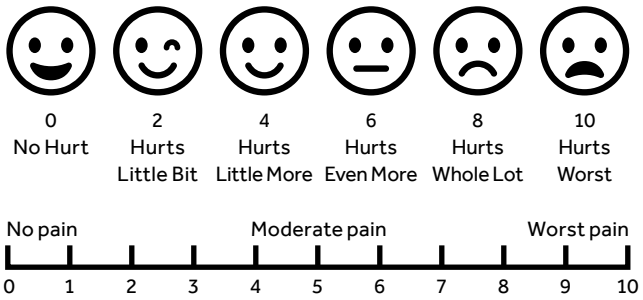
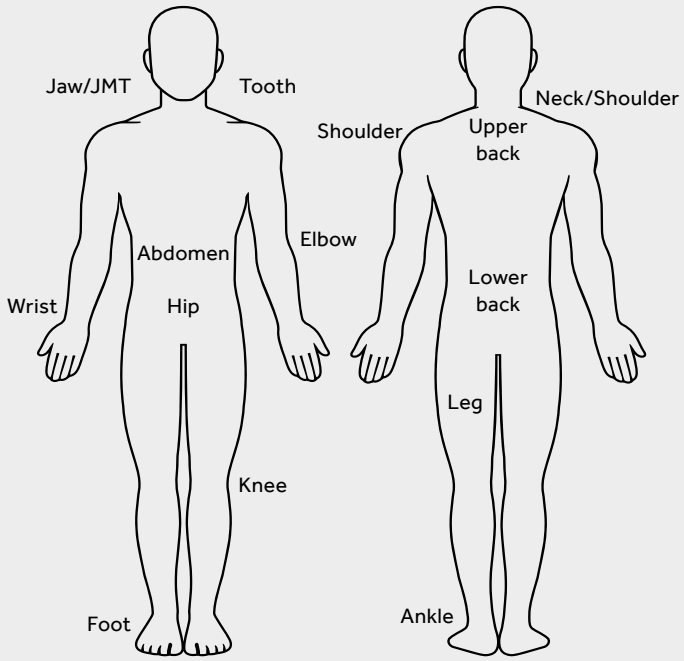
FUNCTIONAL STATUS ASSESSMENT

Activities of daily living *(ADL's)* - Please circle those that apply.	
Which of the following can you do on your own without help?	☐ Yes ☐ No ☐ I don't use tobacco
Does someone help you at home? If yes, please provide Caregiver Name:	☐ Yes ☐ No ☐ Spouse ☐ Children ☐ Other: _____ ☐ Aide/Caregiver #: _____
Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experienced leaking of urine?	☐ Yes When cough/sneeze ☐ No I don't know
Instrumental activities of daily living *(IADL's)* - Please circle those that apply.	
Which of the following can you do on your own without help?	Shop for groceries Use the telephone Housework Handle finances Take medication Make meals Drive/Use public transportation None

HOME/SAFETY

What is your housing situation like? *(Check all that apply)*	☐ Live with one or more children or dependent ☐ Live in an assisted living facility ☐ Live in a nursing facility ☐ Live alone ☐ I have housing today, but I am worried about losing housing in the future ☐ I do not have housing *(I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)*
Do you have a problem with any of the following at your home? *(Check all that apply)*	☐ Bug infestation ☐ Mold ☐ Lead paint or pipes ☐ Inadequate heat ☐ Oven or stove not working ☐ No or not working smoke detectors ☐ Water leaks ☐ None of the above
Do you feel safe in your home?	☐ Yes ☐ No
Does your home have working smoke alarms?	☐ Yes ☐ No ☐ I don't know
Do you have throw rugs on your floor(s)?	☐ Yes ☐ No
Do you have handrails in the bathroom?	☐ Yes ☐ No
Do you have proper lighting in your home?	☐ Yes ☐ No
Do you have handrails for the stairs?	☐ Yes ☐ No ☐ I don't have stairs
Do you fasten your seatbelt in vehicles?	☐ Yes ☐ No ☐ I don't ride in vehicles

PAIN ASSESSMENT

In the past 2 weeks, how often have you felt pain?	☐ Almost all of the time ☐ Most times ☐ Sometimes ☐ Almost Never ☐ Never
Where is the pain? *(Mark all areas in which pain is present)* Rate your pain on the following scale:  	
How do you treat the pain?	☐ Medication ☐ Rest ☐ Heat/Cold ☐ Therapy ☐ I don't treat my pain

RISK FOR FALLING

Which of these assistive devices do you use? *(Please circle all that apply)*	☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Other ☐ None
Do you have trouble with your balance?	☐ Yes ☐ No
Have you fallen 2 or more times or have had a fall with injury in the past year?	☐ Yes ☐ No
Are you afraid of falling?	☐ Yes ☐ No
Do you have any amputations?	☐ Yes ☐ No If yes, where: _____

SENSORY ABILITY *(please circle all that apply)*

Do you have problems with vision? Eye Doctor name: _____	☐ Yes ☐ No If yes, please identify: ☐ Legally blind ☐ Cataracts ☐ Diabetic Retinopathy ☐ Other: _____
Do you use eyeglasses or contacts?	☐ Yes ☐ No
Do you have problems with your hearing? ENT/Hearing Specialist name: _____	☐ Yes ☐ No If yes, please identify: ☐ Partial hearing loss ☐ Deaf ☐ TTY ☐ Other: _____
Do you use hearing aids or other devices to help you hear?	☐ Yes ☐ No

SOCIAL/EMOTIONAL SUPPORT *(please circle all that apply)*	
Which of the following applies to you? *(Please check all that apply)*	☐ I have a supportive family ☐ I have supportive friends ☐ I participate in church, clubs, or other groups ☐ None
How often do you get out and meet with family and friends?	☐ Often ☐ Sometimes ☐ Almost Never ☐ Never
Describe your current living situation.	☐ Alone ☐ Spouse ☐ Children ☐ Homeless ☐ Assisted living facility ☐ Don't have a stable home

ADVANCE DIRECTIVES	
Does your family or friends know what you want in an emergency situation or if you could not speak for yourself? *(Check all that apply)* If you have any of the following, it would be helpful to have a copy provided to us for your medical record.	☐ Yes, I have a living will ☐ Yes, I have a power of attorney ☐ Yes, I have a MOLST ☐ Yes, I have a POLST ☐ Yes, I have completed 5 wishes ☐ No
Would you like more information	☐ Yes ☐ No ☐ Unsure

ALLERGIES – DRUGS, FOOD, ENVIRONMENT		

MEDICATIONS – PRESCRIPTIONS, VITAMINS, OVER-THE-COUNTER			
Name	**Dose**	**Date Started**	**Condition Treating**

SELF & FAMILY HISTORY *(mark the columns that apply)*						
	None	**Self**	**Parent**	**Brother**	**Sister**	**Child**
Congestive Heart Failure						
Diabetes						
COPD (Chronic Lung Disease) or Asthma						
Hypertension						
Stroke						
Kidney Disease						
Obesity						
Liver Disease						
Bipolar Disorder or Schizophrenia						
Dementia						
Cancer						
Depression						

OTHER PHYSICIANS/HEALTHCARE PROVIDERS		
Specialty	**Physician Name**	**Last Seen**
Cardiologist		
Dermatologist		
Ear, Nose, & Throat (ENT)		
Endocrinologist		
Eye/Optometry/Ophthalmologist		
Gastroenterologist		
Gynecologist		
Hematologist/Oncologist		
Nephrologist		
Neurologist		
Orthopedist		
Podiatrist		
Pulmonologist		
Psychiatrist/Psychologist		
Rheumatologist		
Urologist		
Other:		

This additional PHQ-9 screening should only be provided to the patient to complete, or be conducted through patient interview by a clinical staff member, **IF** the PHQ-2 was positive.

DEPRESSION PHQ-9				
In the past 2 weeks, how often have you been bothered by the following problems:	**Not at all:**	**Several days:**	**More than half of those days:**	**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're a failure, or have let yourself or 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've been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Total Score:

If you checked off any of the problems in this section, 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 at all	Somewhat	Very difficult	Extremely difficult