ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Michigan Healthcare Professionals, PC and Medicare want you to receive Wellness Care...Healthcare that may lower your rick for illness or injury. The term "Physical" is often used to describe wellness care. But Medicare does not fully pay for head-to-toe physical examination. Medicare does pay for wellness visit at no cost to you once per year to identify health risk and help you reduce them. At your wellness visit, our healthcare team will take a complete history and provide several other services:

-SCREENINGS TO DETECT DEPRESSION, RISK OF FALLING AND OTHER PROBLEMS

-A LIMITED EXAM TO CHECK YOUR PULSE, BLOOD PRESSURE, WEIGHT, HEIGHT, AND BMI.

-RECOMMENDATIONS FOR OTHER WELLNESS SERVICES AND HEALTHY LIFESTYLE CHANGES

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

A wellness visit does not deal with new or existing health problems. That would be a separate service and would therefore require a separate visit. Please let our staff know if you need the doctor's help with a health problem, a medication refill or something else, so we can schedule an appointment for you. The Medicare Wellness Visit is just another tool for us to use to keep you healthy.

At the completion of your Annual Wellness Visit you will get a copy of your customized prevention plan letting you know which screenings and other preventative services you should get.

We hope that you get the most from your Medicare Wellness benefits. Please contact us with any questions.

Thank You,

Michigan Healthcare Professionals, PC

ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name: Date of Birth:

Name_____ DOB_____

PLEASE INDICATE THE NAMES OF ANY SPECIALISTS YOU ARE CURRENTLY SEEING:

(ie, Cardiologist, Gastroenterologists, Gynecologist, Pulmonologist, Nephrologist, Neurologist, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PLEASE LIST ALL OF YOUR MEDICATIONS:

Please list all medications that you are currently taking: Include all prescription medication, over the counter medication, and any vitamins/herbal remedies.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____

ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name: Date of Birth:

SOCIALHISTORY:

I currently smoke? Yes No

DEPRESION SCREENING (PHQ-2)

OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	*NOT AT ALL*	*SEVERAL DAYS*	*MORE THAN ONE-HALF THE DAYS*	*NEARLY EVERY DAY*
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

FAMILY HISTORY:

List any Changes in your Family history: (□No change)

FUNCTIONAL ABILITY(ADL):

Do you handle your own medication? Yes No

Do you handle your own finances? Yes No

Do you have an unsteady gait or difficulty walking? Yes No

Are you having trouble performing tasks you've done all your life, like cooking or balancing the checkbook? Yes No

ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name: Date of Birth:

FALL SCREENING: Desmond Fall Risk Questionnaire

Yes	No	Have you had a fall or near fall in the past year?
Yes	No	Do you have a fear of falling that restricts your activity?
Yes	No	Do you experience dizziness or a sensation of spinning when you lie down, tilt your head back, or roll over in bed?
Yes	No	Do you feel uneasy or unsteady when walking down the aisle of a supermarket, or in an area congested with other people?
Yes	No	Do you have difficulty walking in the dark, or on uneven surfaces such as gravel or a Sloped sidewalk?
Yes	No	Do your feet or toes frequently feel unusually hot or cold, numb or tingly?
Yes	No	Do you wear bifocal or trifocal glasses, or is your vision notably better in one eye?
Yes	No	Do you experience loss of balance, or a lightheaded/faint feeling when you stand up?
Yes	No	Do you take medication for depression, anxiety, nerves, sleep or pain?
Yes	No	Do you take four or more prescription medications daily?
Yes	No	Do you feel like your feet just won't go where you want them to go?
Yes	No	Do you feel like you can't walk a straight line, or are pulled to the side while walking?
Yes	No	Has it been longer than six months since you participated in a regular exercise program?
Yes	No	Do you feel that no one really understands how much dizziness and balance problems affect your quality of life?
Yes	No	Are you interested in improving your balance and mobility?

ADVANCED DIRECTIVES:

Please check if you have the following:

□ Advanced Directives □ Durable Power of Attorney □ Living Will □ DNR

ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

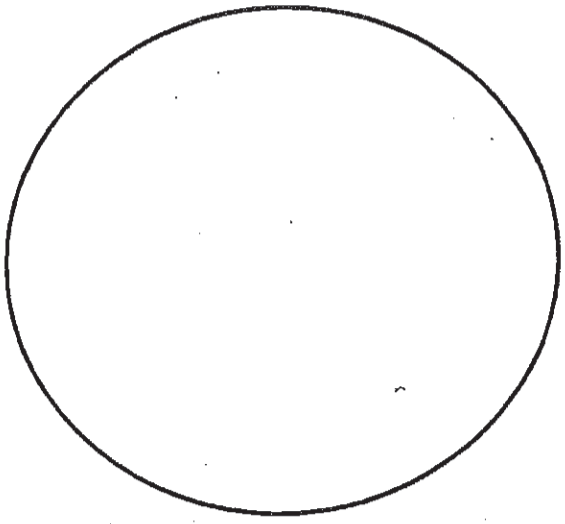
Name: Date of Birth:

COGNITIVE SCREENING: (PROBLEM WITH MEMORY)

I noticed a decrease in my memory	Yes	No
Is it difficult for you to remember the names of common objects, like keys or coins?	Yes	No

CLOCK DRAWING TEST

Draw numbers in the circle to make the circle look like the face of a clock and draw the hands of the clock to read "10 after 11 or 11:10



ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name: Date of Birth:

PREVENTATIVE TESTS:

Please list if you have had any of the following preventative tests:

General
- ☐ Colonoscopy
  Date_____
- ☐ Bone Density
  Date_____
- ☐ Flu vaccine in the last year
  Date_____
- ☐ Pneumonia vaccine in the last 5 years
  Date_____
- ☐ Tetanus vaccine in the last 10 years
  Date_____
- ☐ Shingles vaccine
  Date_____

History Heart Disease
- ☐ EKG
  Date_____
- ☐ Echocardiogram
  Date_____
- ☐ Cholesterol Screening
  Date_____

Women Only
- ☐ Mammogram
  Date_____
- ☐ Pap Smear
  Date_____

Men Only
- ☐ PSA
  Date_____

Diabetic Patients
- ☐ Hgb A1c
  Date_____
- ☐ LDL
  Date_____
- ☐ Eye Exam
  Date_____

PMH

Have you had any of the following: (Feel free to add comments as you see fit)

Allergies/Hay Fever	Yes	No	High Cholesterol	Yes	No
Alcoholism/Drug Abuse	Yes	No	High Blood Pressure	Yes	No
Anemia/Low Blood Count	Yes	No	Kidney Stones	Yes	No
Arthritis	Yes	No	Kidney Problems	Yes	No
Asthma	Yes	No	Liver Problems	Yes	No
Back Problems	Yes	No	Osteoporosis	Yes	No
Breathing Problems (COPD or Emphysema)	Yes	No	Prostate Problems	Yes	No
			Seizures/Epilepsy	Yes	No
Cancer Type:	Yes	No	Sickle Cell Disease	Yes	No
			Stroke	Yes	No
Diabetes	Yes	No	Stomach Problems	Yes	No
Depression	Yes	No	Thyroid Disease	Yes	No
Glaucoma	Yes	No			
Heart Trouble	Yes	No	**Please add others:**		
Headaches(migraine)	Yes	No			

ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name: Date of Birth:

HEALTH MAINTENANCE CHECKLIST (For Provider only)

Everyone:

- Alcohol and Substance Abuse
- Smoking assessment
- Blood pressure and BMI

Men

- Cholesterol
- Colorectal cancer screening (FOBT yearly, Sigmoidoscopy within 5 year, or colonoscopy within 10 years)
- Prostate cancer screening
- AAA (ultrasound): age > 65 and smoker, or CAD, CVD, PVOD.

Women

- Cervical cancer screening
- Breast cancer screening (mammogram every other year)
- Cholesterol
- Colorectal cancer screening
- Osteoporosis screening

Blood Pressure_____BMI_____.

☐I have performed medication reconciliation, reviewed & updated PMH, FH, and SH. Moreover, I have reviewed functional ability, fall screen, depression screen, and cognitive screen and furnished personalized health advice to the beneficiary with the goal of improving their overall wellbeing.

☐If BMI greater than 30 or less than 18.5 provided counseling to help mitigate nutrition issues.

☐If LDL is not at goal made a follow-up appointments was made to go over the of action plan to reduce LDL.

☐Provided Tobacco abuse cessation intervention/counseling

☐Follow up plan was made to address positive Depression Screen and stared depression action plan.

Fall Screen Intervention plan below:

☐Refer to physical therapy to assess gait & balance, provide one-on-one progressive gait & balance retraining, strengthening exercises, & recommend & teach correct use of assistive devices.

☐Counsel patient about reducing fall hazards.

☐Consult Occupational therapist for Home safety evaluation