ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name:_____ DOB:_____

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

(i.e., Cardiologists, Gastroenterologists, Gynecologists, Pulmonologists, Nephrologists, Neurologists, 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.

SOCIAL HISTORY:

I currently Smoke	Yes / No	Frequency:_____
I currently consume Alcohol	Yes / No	Frequency:_____
I currently use THC	Yes / No	Frequency:_____
I currently use Opioids	Yes / No	Frequency:_____

FAMILY HISTORY:

List any changes in your family history: (☐ No Change)

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Name:_____ DOB:_____

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

ADVANCED DIRECTIVES:

Please check if you have the following:

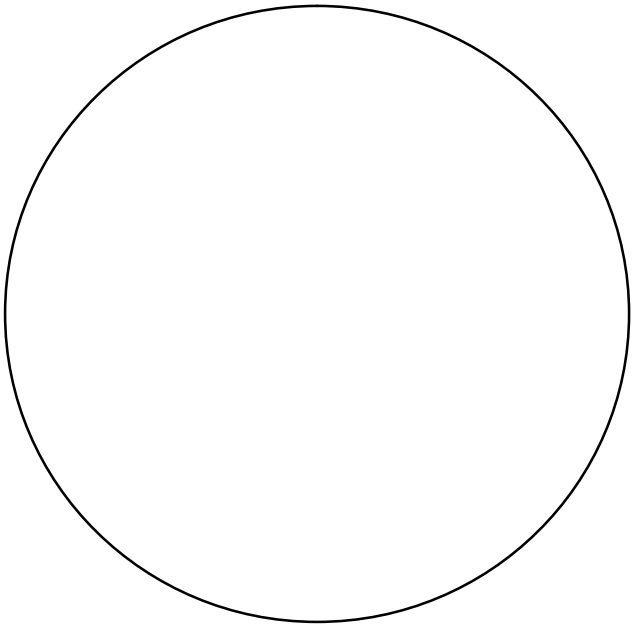
___ Advanced Directives ___ Durable Power of Attorney ___Living Will ___DNR

COGNITIVE SCREENING: (PROBLEM WITH MEMORY)

I noticed a decrease in my memory	Yes / No
It is difficult for me 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."



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Name:_____ **DOB:**_____

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 Year
Date:_____
__ Tetanus Vaccine in the last Year
Date:_____
__ Shingles Vaccine in the last Year
Date:_____
__ Covid-19 Vaccine in the last Year
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:_____

PATIENT HISTORY:

****This section is to be completed by the Provider ONLY**** ***Not to be completed by the patient.***

___ Reviewed Medical & Surgical History

Provider Initials: _____

ANNUAL WELLNESS VISIT

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Name:_____ **DOB:**_____

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 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 in a straight line, or are pulled to the side 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 like?
Yes / No	Are you interested in improving your balance and mobility?

LAKES INTERNAL MEDICINE

Patient Name: _____
Date of Birth: _____

Starting the Conversation: Nutrition

Over the past few months: Check which best applies *(number in parenthesis is the number that should be added up into your total score)*

1. How many times a week did you eat fast food meals or snacks?	Less than 1 __(0)	1-3 times __(1)	4 or more times __(2)
2. How many servings of fruit did you eat each day?	5 or more __(0)	3-4 times __(1)	2 or less __(2)
3. How many servings of vegetables did you eat each day?	5 or more __(0)	3-4 times __(1)	2 or less __(2)
4. How many regular sodas or glasses of sweet tea did you drink each day?	Less than 1 __(0)	1-2 times __(1)	3 or more __(2)
5. How many times a week did you eat beans (like pinto or black), chicken, or fish?	3 or more times __(0)	1-2 times __(1)	Less than 1 time __(2)
6. How many times a week did you eat regular snack chips or crackers (not low-fat)?	1 time or less __(0)	2-3 times __(1)	4 or more times __(2)
7. How many times a week did you eat desserts and other sweets (not low fat)?	1 time or less __(0)	2-3 times __(1)	4 or more times __(2)
8. How much margarine, butter, or meat fat do you use to season vegetables or put on potatoes, bread, or corn?	Very Little __(0)	Some __(1)	A lot __(2)

Summary Score (Sum of all items): _____

(Scale developed by: the Center for Health Promotion and Disease Prevention, University of North Carolina at Chapel Hill, and North Carolina Prevention Partners)

Physical Activity Vital Sign (PAVS)

Question 1: For an average week in the last 30 days, how many days per week did you engage in moderate to vigorous physical activity (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)?
_____ days

Question 2: On those days that you engage in moderate to vigorous physical activity, how many minutes, on average, do you exercise?

_____ minutes

Total minutes per week of physical activity (multiply #1 by #2)

_____ minutes per week

Question 3: During the past month, how many times per week did you do physical activities or exercises to strengthen your muscles?

_____ days

Using the Physical Activity Vital Sign ACSM National guidelines recommend 150 minutes per week of moderate intensity physical activity. In place of moderate intensity activity, you can complete 75 minutes of vigorous intensity activity, or an equivalent combination of moderate and vigorous intensity physical activity. 1 minute of vigorous activity is equal to 2 minutes of moderate activity. • You can perform activity in multiple "bouts" of any length throughout the day to add up to the recommended 150 minutes/week. Although light intensity physical activity (such as a casual walk) is not assessed by the PAVS, it positively impacts health.

Patient Name:

DOB:

LAKES INTERNAL MEDICINE

Advance Beneficiary Notice of Non-coverage (ABN)

Medicare doesn't pay for everything, even some care you or your health care provider think you need. **We expect Medicare may not pay for the item, test, service or care listed below.** If Medicare doesn't pay, you may have to pay.

Item, test, service or care	Reason Medicare may not pay	Estimated cost
Hands on Physical Exam, and any office services that may be rendered such as: Urinalysis, EKG, Injections, Spirometry, Rapid Testing, etc.	Portion of the services may be applied to a co-insurance, deductible or deemed as not medically necessary. All services are paid according to the benefits at the time of service.	

What to do now

- Read this notice to make an informed decision about your care.
- Ask any questions you have.
- Choose one option below to let us know if you still want to get the item, test, service or care.

Choose ONE option below. We can't choose for you.

If you choose Option 1 or 2, we may help you use any other insurance you might have, but Medicare can't require us to do this.

○ **Option 1: I want the item, test, service or care listed above, and I want Medicare to be billed for an official decision on payment, which I'll get on a Medicare Summary Notice (MSN).** You can ask to be paid now. I understand that if Medicare doesn't pay, I'm responsible to pay, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles.

○ **Option 2: I want the item, test, service or care listed above, but don't bill Medicare.** You can ask to be paid now and I'm responsible to pay. I understand that I can't appeal, since Medicare isn't billed.

○ **Option 3: I don't want the item, test, service or care listed above.** I understand I'm not responsible for payment and I can't appeal to see if Medicare would pay.

Additional information:

This notice gives our opinion, not an official Medicare decision. For other questions about this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Signing below means you received and understand this notice. You can ask to get a copy.

Signature	**Date** (mm/dd/yyyy)

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

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