



Medicare Wellness Visit

Medicare covers a one-time preventive visit within the first 12 months that you have Medicare Part B. This visit is called the “Welcome to Medicare” preventive visit.

Health Recommendations

As of January 2011, if you’ve had Part B for longer than 12 months, Medicare beneficiaries can get a free Annual Wellness Visit. During this visit, you can work with your physician to develop a personalized prevention plan. This plan will help you take advantage of another important benefit—the benefit that allows you to receive free preventive care.

The Medicare Annual Wellness Visit is not the same as a physical exam. If your provider has to take a deeper dive into a chronic condition, treat an illness or address an injury during your Annual Wellness Visit this will not be considered a preventive service. You will be asked to schedule a separate visit to address your chronic condition, injury or illness.

Preventive Services

Preventive services include screenings, vaccinations, and counseling services. In other words, services like blood tests to check your cholesterol, your annual flu shot, or an appointment to talk to your doctor or other health care provider about how to stop smoking. These services can prevent you from getting sick or help you determine if you are at risk for certain conditions so you can take necessary steps to prevent them.

The annual wellness visit benefit includes the following services:

- Routine measurements, such as your height, weight, blood pressure, and body mass index (BMI).
- Review of your individual medical and family history.
- Review of the medications, supplements, and vitamins that you are currently taking.
- Discussion of the care you are currently receiving from other health care providers.
- Review of your functional ability and level of safety (for example, your risk of falling at home), including any cognitive impairment, as well as a screening for depression.
- Discussion of personalized health advice that takes into account your risk factors and specific health conditions or needs, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition.
- Discussions of referrals to other appropriate health education or preventive counseling services that may help you minimize or treat potential health risks.
- Planning a schedule for the Medicare screening and preventive services you will need over the next five to 10 years.

Preparing for your visit:

- Complete the Medicare Health Assessment Form found below.
- Bring a list of current medication
- Bring photo ID and Insurance card

MEDICARE WELLNESS CHECKUP

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

1. What is your age?

- 65-69. 70-79. 80 or older.

2. Are you a male or a female?

- Male. Female.

3. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

- Not at all.
 Slightly.
 Moderately.
 Quite a bit.
 Extremely.

4. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

- Not at all.
 Slightly.
 Moderately.
 Quite a bit.
 Extremely.

5. During the **past four weeks**, how much bodily pain have you generally had?

- No pain.
 Very mild pain.
 Mild pain.
 Moderate pain.
 Severe pain.

6. During the **past four weeks**, was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

- Yes, as much as I wanted.
 Yes, quite a bit.
 Yes, some.
 Yes, a little.
 No, not at all.

Your name: _____

Today's date: _____

Your date of birth: _____

7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

- Very heavy.
 Heavy.
 Moderate.
 Light.
 Very light.

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)

- Yes. No.

9. Can you go shopping for groceries or clothes without someone's help?

- Yes. No.

10. Can you prepare your own meals?

- Yes. No.

11. Can you do your housework without help?

- Yes. No.

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

- Yes. No.

13. Can you handle your own money without help?

- Yes. No.

14. During the **past four weeks**, how would you rate your health in general?

- Excellent.
 Very good.
 Good.
 Fair.
 Poor.

15. How have things been going for you during the **past four weeks**?

- Very well; could hardly be better.
- Pretty well.
- Good and bad parts about equal.
- Pretty bad.
- Very bad; could hardly be worse.

16. Are you having difficulties driving your car?

- Yes, often.
- Sometimes.
- No.
- Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

- Yes, usually.
- Yes, sometimes.
- No.

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble eating well.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth or denture problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems using the telephone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tiredness or fatigue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Have you fallen two or more times in **the past year**?

- Yes. No.

20. Are you afraid of falling?

- Yes. No.

21. Are you a smoker?

- No.
- Yes, and I might quit.
- Yes, but I'm not ready to quit.

22. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- 10 or more drinks per week.
- 6-9 drinks per week.
- 2-5 drinks per week.
- One drink or less per week.
- No alcohol at all.

23. Do you exercise for about 20 minutes three or more days a week?

- Yes, most of the time.
- Yes, some of the time.
- No, I usually do not exercise this much.

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

- Yes. No.

Keeping track of your medications?

- Yes. No.

25. How often do you have trouble taking medicines the way you have been told to take them?

- I do not have to take medicine.
- I always take them as prescribed.
- Sometimes I take them as prescribed.
- I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?

- Very confident.
- Somewhat confident.
- Not very confident.
- I do not have any health problems.

27. What is your race? (**Check all that apply.**)

- White.
- Black or African American.
- Asian.
- Native Hawaiian or other Pacific Islander.
- American Indian or Alaskan Native.
- Hispanic or Latino origin or descent.
- Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.