Platte Valley
Internal Medicine
& Pulmonary

Medicare Annual Wellness Visit
Health Risk Assessment

Dear Patient,

Medicare covers an Annual Wellness Visit once every 12 months. Some Medicare Advantage plans may cover an Annual Wellness Visit more frequently. We encourage you to be familiar with your insurance policy and coverage.

The Annual Wellness Visit is not the same thing as what many people often refer to as their yearly physical exam. Medicare is very specific about what the Annual Wellness Visit, appointment includes and excludes.

At the Annual Wellness Visit your doctor will review your medical history, screen you for depression, and determine your functional ability and level of safety. You will be provided with a personalized prevention plan to help keep you healthy. The visit does not include a comprehensive physical exam, discussion or testing regarding any new or current medical problems, conditions or medications. You may schedule another visit to address those issues or your doctor may charge your insurance the usual fees for such services that are beyond the scope of the Annual Wellness Visit.

Please bring the following to your appointment:

- Your insurance card(s)
- Completed questionnaire enclosed with this letter
- Your prescription medication and over-the counter medication bottles including vitamins and supplements
- Immunization records
- Copies of Advance Directives, if applies

We look forward to seeing you.

Platte Valley Internal Medicine & Pulmonary providers and staff

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Patient Name: ______________________________ Date of Birth: ______________

GENERAL HEALTH	
1. Do you take all of your medications as prescribed?	☐ Yes ☐ No ☐ Sometimes ☐ Almost never ☐ I don't take medication
2. How is the health of your mouth and teeth?	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know
3. Do you have a dentist that you visit regularly?	☐ Yes ☐ No
4. How many times in the last six months have you been to the emergency room?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
5. How many times in the last six months were you admitted to the hospital?	☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't know
TOBACCO, ALCOHOL AND DRUG USE (HCPCS CODES 99406, 99408 and G0442)	
6. Do you use any tobacco products?	☐ Yes ☐ No If yes, what type? ____________________ How much per day? ___________________
7. If yes, are you interested in quitting?	☐ Yes ☐ No
8. How often do you drink?	☐ None ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily
9. When you drink, how many drinks do you consume?	☐ 1-2 ☐ 3-4 ☐ More
10. Have you ever been treated for alcoholism?	☐ Yes ☐ No If yes, when?
11. Do you use recreational drugs?	☐ Yes ☐ No
12. Have you ever abused prescription drugs?	☐ Yes ☐ No If yes, what kind?
13. Are you interested in receiving help for any type of substance abuse?	☐ Yes ☐ No

NUTRITION	
14. How would you rate your diet choices?	☐ Very healthy ☐ Mostly healthy ☐ Not healthy ☐ I don't know if it is healthy
15. In the past year has your weight changed?	☐ Gained weight ☐ Lost weight ☐ Stayed the same If yes, how many pounds have you lost or gained? _______lbs.

PHYSICAL ACTIVITY	
16. How many times a week do you exercise?	☐ None ☐ 1-2 ☐ 3-4 ☐ 5+ ☐ I don't exercise
17. On the days that you exercised, how long did you exercise?	☐ 0-30 min. ☐ 30 min. to 1 hour ☐ More than 1 hour ☐ I don't know
18. How intense is your exercise?	☐ Light ☐ Moderate ☐ Heavy ☐ Very Heavy ☐ I don't know

SLEEP	
19. Do you snore or has anyone told you that you snore?	☐ Yes ☐ No
20. In the past 7 days, how often have you felt sleepy during the daytime?	☐ Often ☐ Sometimes ☐ Almost never ☐ Never

FUNCTIONAL STATUS ASSESSMENT (CPT II CODE 1170F)	
	☐ Shopping ☐ Housekeeping ☐ Managing finances

21. Which of the following can you do on your own without help?	☐ Taking medications ☐ Preparing meals ☐ Drive ☐ Bathing ☐ Dressing ☐ Toileting ☐ Eat
22. Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?	☐ Yes ☐ No
23. Which of these assistive devices do you use?	☐ Cane ☐ Walker ☐ Wheelchair ☐ Crutches ☐ Other: ________________________ ☐ None
24. Do you have trouble with your balance?	☐ Yes ☐ No
25. Have you fallen in the last six months?	☐ Yes ☐ No If yes, list any injuries: _______________ ____
26. Do you have problems with vision?	☐ Yes ☐ No
27. Do you use eyeglasses or contact lenses?	☐ Yes ☐ No
28. Do you have trouble hearing the television or radio when others do not?	☐ Yes ☐ No
29. Do you use hearing aids or other devices to help You hear?	☐ Yes ☐ No

PAIN ASSESSMENT (CPT II CODES 1125F, 1126F)	
30. In the past two (2) weeks, how often have you felt pain?	☐ All of the time ☐ Most of the time ☐ Sometimes ☐ Almost Never ☐ No pain
31. If yes, where is your pain? ______________________ ____ **OR** Mark the diagram in the box to the right with all areas you have pain.	
32. Rate your pain on a scale of 0-10, with 0 being no Pain and 10 being the worst pain: **Circle the number on the scale.**	PAIN SCORE 0–10 NUMERICAL RATING 0 1 2 3 4 5 6 7 8 9 10 No pain / Moderate pain / Worst possible pain
33. How do you treat the pain?	☐ Medication Type: ______________________________ ☐ Rest ☐ Heat or cold ☐ Therapy ☐ Other ☐ No treatment plan ☐ No pain

HOME/SAFETY	
34. What is your living situation?	☐ Alone ☐ With my spouse or other family ☐ With a friend or roommate ☐ In a nursing home or assisted living facility
35. Do you feel safe at home?	☐ Yes ☐ No
36. Does your home have working fire alarms?	☐ Yes ☐ No ☐ I don't know
37. Do you fasten your seatbelt in vehicles?	☐ Yes ☐ No ☐ I don't ride in vehicles
DEPRESSION – PHQ-9 (HCPCS CODE G0444)	
In the last two (2) weeks, how often have you been bothered by any of the following problems?	
38. Little interest or pleasure in doing things:	☐ Not at all ☐ Several days

	☐ More than half the days ☐ Nearly everyday
39. Feeling down, depressed or hopeless:	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday
40. Trouble falling or staying asleep or sleeping too much:	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday
41. Feeling tired or having little energy:	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday
42. Poor appetite or overeating:	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday
43. Feeling bad about yourself or that you're a failure or have let yourself or your family down:	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday
44. Trouble concentrating on things, such as reading the newspaper or watching television:	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday
45. 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:	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday
46. Thoughts that you would be better off dead or of hurting yourself:	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday
47. If you checked off any 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 difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

ADVANCED DIRECTIVES (CPT II CODES 1157F, 1158F; HCPCS CODE S0257	
48. Do you have any of the following: **Check all that apply.**	☐ Living Will ☐ Advanced Directive ☐ Colorado MOST Form ☐ None
49. Have you provided your provider a copy?	☐ Yes ☐ No ☐ I don't know
50. Would you like more information?	☐ Yes ☐ No

ANNUAL SCREENING TESTS			
	Date		Date
Hearing Exam		Prostate Exam	
Vision Exam		PSA (blood test)	
Mammogram		Colonoscopy	

Pap Smear		Hemoccult Card	
Dexa Scan		AAA Screening	

VACCINATIONS			
	Date		Date
Flu Shot		Shingles Vaccine	
Pneumovax		COVID-19	
Prevnar 13		Tetanus Shot	

SELF AND FAMILY HISTORY						
Mark the columns that apply:	**Self**	**Father**	**Mother**	**Brother**	**Sister**	**Child**
Cancer						
COPD/Lung Disease/Asthma						
Coronary Heart Disease						
Dementia						
Depression/Mental Illness						
Diabetes						
Glaucoma						
Heart Attack						
High Blood Pressure						
Kidney Disease						
Liver Disease						
Obesity						
Stroke						

OTHER PHYSICIANS OR HEALTHCARE PROVIDERS		
Specialty	**Provider Name**	**Date Last Seen**
Cardiologist		
Dermatologist		
Ear, Nose and Throat		
Endocrinologist		
Eye Doctor		
Gynecologist		
Pulmonologist		
Physical Therapist		
Urologist		

MEDICATIONS – PRESCRIPTIONS, VITAMINS AND OVER THE COUNTER (CPT II CODE 1159F, 1160F)	
Medication	**Dose**

ALLERGIES (DRUG)	
Allergy	**Reaction**

Reviewed by:	
Provider Signature:	Date: