

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

**Platte Valley  
Internal Medicine  
& Pulmonary**

**Medicare Annual Wellness Visit  
Health Risk Assessment**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**GENERAL HEALTH**

1. Do you take all of your medications as prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost never <input type="checkbox"/> I don't take medication
2. How is the health of your mouth and teeth?	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> I don't know
3. Do you have a dentist that you visit regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. How many times in the last six months have you been to the emergency room?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
5. How many times in the last six months were you admitted to the hospital?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know

**TOBACCO, ALCOHOL AND DRUG USE (HCPCS CODES 99406, 99408 and G0442)**

6. Do you use any tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, what type? _____ How much per day? _____
7. If yes, are you interested in quitting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. How often do you drink?	<input type="checkbox"/> None <input type="checkbox"/> Rarely <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily
9. When you drink, how many drinks do you consume?	<input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> More
10. Have you ever been treated for alcoholism?	<input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, when? _____
11. Do you use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you ever abused prescription drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, what kind? _____
13. Are you interested in receiving help for any type of substance abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**NUTRITION**

14. How would you rate your diet choices?	<input type="checkbox"/> Very healthy <input type="checkbox"/> Mostly healthy <input type="checkbox"/> Not healthy <input type="checkbox"/> I don't know if it is healthy
15. In the past year has your weight changed?	<input type="checkbox"/> Gained weight <input type="checkbox"/> Lost weight <input type="checkbox"/> 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?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't exercise
17. On the days that you exercised, how long did you exercise?	<input type="checkbox"/> 0-30 min. <input type="checkbox"/> 30 min. to 1 hour <input type="checkbox"/> More than 1 hour <input type="checkbox"/> I don't know
18. How intense is your exercise?	<input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy <input type="checkbox"/> I don't know

**SLEEP**

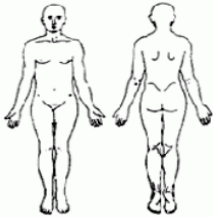
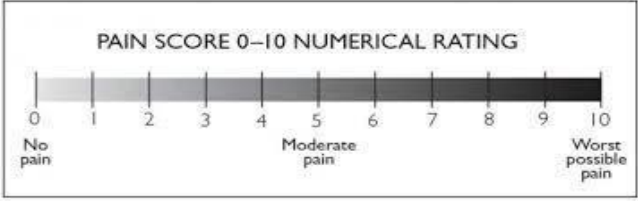
19. Do you snore or has anyone told you that you snore?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. In the past 7 days, how often have you felt sleepy during the daytime?	<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost never <input type="checkbox"/> Never

**FUNCTIONAL STATUS ASSESSMENT (CPT II CODE 1170F)**

<input type="checkbox"/> Shopping <input type="checkbox"/> Housekeeping <input type="checkbox"/> Managing finances
--

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

**PAIN ASSESSMENT (CPT II CODES 1125F, 1126F)**

30. In the past two (2) weeks, how often have you felt pain?	<input type="checkbox"/> All of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost Never <input type="checkbox"/> No pain
31. If yes, where is your pain? _____ _____  <b>OR</b> 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:  <b>Circle the number on the scale.</b>	
33. How do you treat the pain?	<input type="checkbox"/> Medication   Type: _____ <input type="checkbox"/> Rest <input type="checkbox"/> Heat or cold <input type="checkbox"/> Therapy <input type="checkbox"/> Other <input type="checkbox"/> No treatment plan <input type="checkbox"/> No pain

**HOME/SAFETY**

34. What is your living situation?	<input type="checkbox"/> Alone <input type="checkbox"/> With my spouse or other family <input type="checkbox"/> With a friend or roommate <input type="checkbox"/> In a nursing home or assisted living facility
35. Do you feel safe at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
36. Does your home have working fire alarms?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
37. Do you fasten your seatbelt in vehicles?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't ride in vehicles

**DEPRESSION – PHQ-9 (HCPCS CODE G0444)**

<b>In the last two (2) weeks, how often have you been bothered by any of the following problems?</b>	
38. Little interest or pleasure in doing things:	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days

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

**ADVANCED DIRECTIVES (CPT II CODES 1157F, 1158F; HCPCS CODE S0257)**

48. Do you have any of the following: <b>Check all that apply.</b>	<input type="checkbox"/> Living Will <input type="checkbox"/> Advanced Directive <input type="checkbox"/> Colorado MOST Form <input type="checkbox"/> None
49. Have you provided your provider a copy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
50. Would you like more information?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: