65 Year Old + or Medicare Wellness Visit

Bestcare Internal Medicine

Name: _____

Date of birth: _____

☐ 1st year of Medicare (G0402) ☐ Initial (G0438) ☐ Subsequent (G0439)

This is a wellness visit which does not deal with new or existing health problems. Any need for the evaluation of new or existing health problems requires more time and a seperate visit.

Any new medication changes since your last visit: _____

General Health

In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Do you eat healthy foods most of the time? ☐ Yes ☐ No

Do you always wear your seatbelt when riding in a car? ☐ Yes ☐ No

Have you had dental care within the past 12 months? ☐ Yes ☐ No

In the past 7 days, how many days did you exercise? ____ days Exercise type: _____

On days when you exercised, for how long did you exercise? ____ minutes per day

Tobacco Use

☐ No ☐ Yes In the last 30 days, have you used tobacco? Number of cigarettes per day ____ Number of Years ____

If yes, are you interested in quitting in the next month? ☐ Yes ☐ No

☐ No ☐ Yes Are you a former smoker? Number of cigarettes per day ____ Number of Years ____

Falls: **Have you fallen within the past year?** ☐ **No** ☐ **Yes**

Do you use or have you been advised to use a cane or walker to get around safely? ☐ No ☐ Yes

Do you feel unsteady when you are walking? ☐ No ☐ Yes

Do you steady yourself by holding onto furniture when walking at home? ☐ No ☐ Yes

Are you worried about falling? ☐ No ☐ Yes

Do you need to push off with your hands when you stand up from a chair? ☐ No ☐ Yes

Do you have some trouble stepping up onto a curb? ☐ No ☐ Yes

Do you often have to rush to the toilet? ☐ No ☐ Yes

Have you lost some feeling in your feet? ☐ No ☐ Yes

Do you take medicine that sometimes makes you feel lightheaded or more tired than usual? ☐ No ☐ Yes

Does your home have loose rugs on the floor? ☐ No ☐ Yes

Does your main bathroom lack grab bars? ☐ No ☐ Yes

Do any of your stairs lack handrails? ☐ No stairs ☐ No ☐ Yes

Does your home have poor lighting from bathroom to bedroom? ☐ No ☐ Yes

Function, Safety and Hearing - Do you need help with:

Phone?	☐ No	☐ Yes	Managing meds?	☐ No	☐ Yes
Transportation?	☐ No	☐ Yes	Managing money?	☐ No	☐ Yes
Shopping?	☐ No	☐ Yes	Dressing?	☐ No	☐ Yes
Preparing meals?	☐ No	☐ Yes	Bathing?	☐ No	☐ Yes
Housework?	☐ No	☐ Yes	Transferring positions?	☐ No	☐ Yes
Laundry?	☐ No	☐ Yes	**Do you have hearing difficulties?**	☐ No	☐ Yes

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Bestcare Internal Medicine

Social determinants of health screening tool

Are you currently experiencing any of the following concerns? Please check all statements that apply to you at the **current time**. This information will help us understand your most pressing concerns.

1. I have difficulty paying for health care services other than prescription medications.

O Always O Sometime O Never O Do not wish to answer

a. I have trouble paying for dental care.

O Always O Sometime O Never O Do not wish to answer

b. I have trouble paying for doctor bills.

O Always O Sometime O Never O Do not wish to answer

2. I have difficulty accessing or affording transportation to get to doctor appointments, or the pharmacy.

O Always O Sometime O Never O Do not wish to answer

3. I need help with shopping, preparing food, housekeeping, laundry, finances, or managing my medications.

O Always O Sometime O Never O Do not wish to answer

4. I spend most of my time alone, but would rather socialize with other people more often.

O Always O Sometime O Never O Do not wish to answer

5. I have limited or uncertain access to enough food or to nutritious food.

O Always O Sometime O Never O Do not wish to answer

6. I have trouble paying my electricity, gas, or water bills.

O Always O Sometime O Never O Do not wish to answer

7. I have a place to live now, but I am worried about losing it in the future.

O Always O Sometime O Never O Do not wish to answer

Name: _____ **Date of Birth:** _____

Mood: Do you have a history of depression or are you being treated for depression? ☐ No ☐ Yes

Over the last 2 weeks, have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly Each Day**
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself --or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
Moving or speaking so slowly that other people could have noticed? Or the opposite --being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**

Total Score: _____

Health Maintenance Checklist

If you are Past Due on the Colonoscopy please take a FIT test packet home with you	**DATE R for Refused**
Mammogram (Women only)	
Pap Smear (Women only)	
PSA (Men only)	
Colonoscopy (Preferred), Cologuard or Fit Test	
Bone Density (Dexa)	
Eye Exam	
Immunizations: TDAP: _____ Flu: _____ Prevnar 13: _____ PPSV23: _____ Zoster: _____ Covid-19: 1st: _____ 2nd _____ Brand: _____	

Advance Directives

1. Who speaks for you if you are unable to make a decision for your health?
   Do you have an Advanced Directive? ☐ Yes ☐ No
   a. If you have none, print Advance Directives from caring.com and bring a copy on your next visit.

2. Have you completed the following advance care planning legal documents?

Living Will? ☐ Yes ☐ No

Physician Order for Life-Sustaining Treatment (POLST) ☐ Yes ☐ No

List of current Medical Providers and Suppliers (other than your Primary Care Provider):

_____

Thank you for completing this form. Please keep it until you are in the exam room.

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_____ _____

Patient Signature **Date**