



# 65 Year Old + or Medicare Wellness Visit

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 separate 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

**OVER →**

## 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.  
 Always    Sometime    Never    Do not wish to answer
  - a. I have trouble paying for dental care.  
 Always    Sometime    Never    Do not wish to answer
  - b. I have trouble paying for doctor bills.  
 Always    Sometime    Never    Do not wish to answer
2. I have difficulty accessing or affording transportation to get to doctor appointments, or the pharmacy.  
 Always    Sometime    Never    Do not wish to answer
3. I need help with shopping, preparing food, housekeeping, laundry, finances, or managing my medications.  
 Always    Sometime    Never    Do not wish to answer
4. I spend most of my time alone, but would rather socialize with other people more often.  
 Always    Sometime    Never    Do not wish to answer
5. I have limited or uncertain access to enough food or to nutritious food.  
 Always    Sometime    Never    Do not wish to answer
6. I have trouble paying my electricity, gas, or water bills.  
 Always    Sometime    Never    Do not wish to answer
7. I have a place to live now, but I am worried about losing it in the future.  
 Always    Sometime    Never    Do not wish to answer

**Advanced Primary Care Management- Our providers recommend you sign up!**

**Your insurance offers a Preventive Care Program (APCM):**

**It helps us track your health and screenings**

**Yes! [Enroll Me](#)**

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)	
<b>Colonoscopy (Preferred), Cologuard or Fit Test</b>	
Bone Density (Dexa)	
Eye Exam	
<b>Immunizations:</b> TDAP: _____ Flu: _____ Pevnar 13: _____ PPSV23: _____ Zoster: _____ Covid-19: 1 <sup>st</sup> : _____ 2 <sup>nd</sup> : _____ Brand: _____	

**Advance Directives**

- 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.

- 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.

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

**OVER →**