North Olympic Healthcare NETWORK

240 W Front St. Port Angeles, WA 98362 P:(360) 452-7891

Thank you for participating in your **Medicare Annual Wellness Visit** with North Olympic Healthcare Network as recommended by your primary care provider.

Your provider understands that as we age our "preventive care" needs evolve and more attention needs to be given to our functional status and safety in addition to screening for certain diseases. Medicare recognizes this as well, and has developed a specific benefit called the **Annual Wellness Visit** that addresses these issues.

Your **Medicare Annual Wellness Visit** includes the following elements:

- Establish or update your medical and family history
- Review and list other doctors and suppliers involved in providing your care
- Review and update all of your medications and supplements including vitamins – how often and much of each is taken
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements
- Screening for loss of sensory acuity
- Screening for any cognitive impairment
- Establish a screening schedule or checklist for the next 5 to 10 years
- Provide personalized risk assessment, health advice, and appropriate referrals to health education or preventive services, i.e. smoking cessation, diet, etc.
- Discussion about Advanced Directives

The Medicare Annual Wellness Visit does not have a co-pay requirement and does not include, or pay for, a physical exam and some lab work/blood draws. Specific health concerns are best addressed at another visit with your provider focused on those concerns. Your wellness visit is performed by a nurse specialist with collaboration and oversight by your primary care provider.

Because of these specific Medicare requirements for this examination, we have enclosed a questionnaire for you to **complete before the visit** to assist us in your assessment. **Please answer each question completely and return to NOHN as soon as possible**. Once we have received your completed questionnaire, **we will contact you about scheduling a special time for your Annual Wellness Visit with our nurse specialist:**

Pre-Visit Checklist

- ☐ Fill out questions in the enclosed packet
- ☐ Complete any ordered lab work as soon as possible

Patient Name: _____

Address: _____ _____ _____ _____
Street **Mailing** **City** **State** **Zip Code**

Date of Birth: _____

Age Today: _____

Sex: ☐ **Male**

☐ **Female**

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

The Medicare Annual Wellness Visit (AWV) is a wellness visit during which the patient's medical history, risk factors, functional ability, and routine measurements are captured in order to provide a Personalized Prevention Plan which the patient may choose to follow to maintain good health. The Annual Wellness Visit is NOT the same as a yearly (annual) physical exam.

This form is used in conjunction with the Medicare benefit of an Annual Wellness Visit and is to be updated with each annual visit.

HEALTH FACTORS

Caffeine Use	**Response**
Do you drink caffeine or energy drinks?	Yes ☐ No ☐
Caffeine drinks per day?	_____
Energy drinks per day?	_____

Physical Activity / Exercise	**Response**
How many days a week do you usually exercise?	Days per week: _____
Type of exercise? _____	
How much time do you spend exercising each session?	_____
How intense is your typical exercise? **(Check one)**	Light (stretching or slow walking) ☐
	Moderate (brisk walking) ☐
	Heavy (jogging/swimming) ☐

Motor Vehicle Safety	**Response**
What percent of the time do you fasten your seat belt while in a car?	100% ☐
	75% ☐
	50% ☐
	25% ☐
	0% ☐
Do you ever drive after drinking, or ride with a driver who has been drinking?	Yes ☐ No ☐

Nutrition **Response**

On a typical day, how many servings of fruits and/or vegetables do you eat? _____ servings
On a typical day, how many servings of high fiber or whole grain foods do you eat? _____ servings
On a typical day, how many servings of fried or high-fat foods do you eat? _____ servings

TOBACCO USE

Smoking / Tobacco use **Response**

Do you currently smoke cigarettes or use other types of tobacco? Yes ☐ No ☐

If you are a current smoker, what is your smoking status?
- Every day smoker ☐
- Some days smoker ☐
- Light tobacco smoker ☐
- Heavy tobacco smoker ☐

What year did you start smoking? _____

Are you a former smoker? **(Check one)**
- Yes, but quit ☐
- No, never ☐
- Does not apply ☐

If you quit smoking, how long ago? **(Check one)**
- Less than 6 months ☐
- 6 – 11 months ☐
- 1 – 5 years ☐
- 6 – 15 years ☐
- More than 15 years ☐
- Does not apply ☐

What year did you start smoking? _____
What year did you quit? _____

Do you use other tobacco products? **(Check all that apply)**
- Cigars ☐
- Pipe ☐
- Chewing tobacco/snuff ☐

ALCOHOL USE

Response

Do you drink alcohol? Yes ☐ No ☐

In a typical week, how many drinks per day do you consume? Drinks per day _____

What type of alcohol? (**Check all that apply)**
- Beer ☐
- Hard Liquor ☐
- Mixed Drinks ☐
- Wine ☐
- Other ☐

Do you have a family history of alcoholism? Yes ☐ No ☐

DEPRESSION SCREENING

Depression		**Response**
Over the past 2 weeks, how often have you felt down, depressed or hopeless?		
	(**Check one)**	Nearly every day ☐
		More than half the days ☐
		Several days ☐
		Not at all ☐
Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?		
	(**Check one)**	Nearly every day ☐
		More than half the days ☐
		Several days ☐
		Not at all ☐

FALL RISK FACTORS

Fall Risk Factors		**Response**
Have you fallen from a standing position within the past 6 months?		Yes ☐ No ☐
Do you have incontinence of the bowel or bladder?		
	(**Check all that apply)**	Bowel ☐
		Bladder ☐
		None of the above ☐
Do you find that you have to go to the bathroom more than you like?		Yes ☐ No ☐
Do you have difficulty making it to the bathroom in time?		Yes ☐ No ☐

SCREENING FOR HEARING LOSS

Do you have a problem hearing over the telephone?	Yes ☐ No ☐
Do you have trouble following the conversation when two or more people talk at the same time?	Yes ☐ No ☐
Do people complain that you turn the TV or radio volume up too high?	Yes ☐ No ☐
Do you have to strain to understand conversation?	Yes ☐ No ☐
Do you have trouble hearing in a noisy background?	Yes ☐ No ☐
Do you find yourself asking people to repeat themselves?	Yes ☐ No ☐
Do many people you talk to seem to mumble, or not speak clearly?	Yes ☐ No ☐
Do you misunderstand what others are saying and respond inappropriately?	Yes ☐ No ☐
Do you have trouble understanding the speech of women and children?	Yes ☐ No ☐
Do people get annoyed because you misunderstand what they say?	Yes ☐ No ☐

GENERAL WELL BEING

Sleep	**Response**
How many hours of sleep do you usually get each night?	Hours a night ____

Stress **Response**

How often is stress a problem for you?

(**Check one**)
- Never / rarely ☐
- Sometimes ☐
- Often ☐
- Always ☐

How well do you handle the stress in your life?

(**Check one**)
- I'm usually able to cope effectively ☐
- At times I have problems coping ☐
- I often have problems coping ☐

General Health **Response**

In general, would you say your health is?

(Check one)
- Excellent ☐
- Very Good ☐
- Good ☐
- Fair ☐
- Poor ☐

Daily Aspirin Use **Response**

Have you discussed taking a daily aspirin with your doctor? Yes ☐ No ☐

Social / Emotional Support **Response**

How often do you get the social and emotional support you need?

(**Check one**)
- Always ☐
- Usually ☐
- Sometimes ☐
- Rarely ☐
- Never ☐

FUNCTIONAL ACTIVITIES

Can you get out of bed by yourself? Yes ☐ No ☐

Do you dress yourself without help? Yes ☐ No ☐

Can you prepare your own meals? Yes ☐ No ☐

Do you do your own shopping? Yes ☐ No ☐

Do you write checks and pay your own bills? Yes ☐ No ☐

Do you drive or have other means of transportation for traveling outside of your neighborhood? Yes ☐ No ☐

Are you able to keep track of appointments and family occasions? Yes ☐ No ☐

Are you able to take medicine according to directions, dosing, etc.? Yes ☐ No ☐

Are you able to keep track of current events? Yes ☐ No ☐

Are you still able to play games of skill that you enjoy or work on a favorite hobby? Yes ☐ No ☐

HOME SAFETY

Do you have throw-rugs on hardwood floors in your house?	Yes ☐ No ☐
Do you have pets that stay indoors?	Yes ☐ No ☐
Does your house have smoke alarms and carbon monoxide detectors in good working order?	Yes ☐ No ☐
Does your bathtub contain a safety measure such as a rubber mat or strips?	Yes ☐ No ☐
Is the area in front of your bathtub either carpeted or protected by a bathmat with rubber backing?	Yes ☐ No ☐
Do you have night lights in your house?	Yes ☐ No ☐
Do you have loose or frayed cords or overloaded electrical sockets in your house?	Yes ☐ No ☐
Do you unplug household appliances when not in use?	Yes ☐ No ☐
Do you keep medicines in a safe place and have their directions clearly labeled?	Yes ☐ No ☐
Do you keep poisons, chemicals, or other toxic materials put away in a safe place?	Yes ☐ No ☐
Do you have furniture, such as a coffee table with sharp corners, or a rickety chair that could cause injury?	Yes ☐ No ☐

Patient Signature: _____ Date: _____

Returning this form will prompt a call to schedule your Annual Wellness Visit with our nurse specialist.

Your provider may also:

1. Conduct a vision screening
2. Ask you about Advanced Directives
3. Conduct a five to ten year screening schedule and ask about all of the health care providers involved in your care.

Thank you for choosing North Olympic Healthcare Network!

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