Geauga Family Physicians
Board Certified Family Physicians

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A WORD TO OUR PATIENTS ABOUT MEDICARE AND WELLNESS CARE

Dear Patient,

We would like you to receive wellness care which is health care that may lower your risk of illness. Medicare pays for some wellness care, although it does not pay for a comprehensive physical.

Medicare pays for a wellness visit once every year. Our health care team will see that your visit includes:

- A health history
- A limited exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- Recommendations for other wellness services and healthy lifestyle changes.

Before your appointment you will be asked to complete the Medicare Wellness Checkup Form and ***bring the completed form to your visit along with your medication bottles****. If your appointment is in the morning, please come to this appointment fasting in case your physician orders blood work.*

A wellness visit does not deal with new or existing health problems. That would be a separate service and requires a longer appointment. Please let our scheduling staff know if you need the doctor's help with a health problem, a medication refill or something else. We may need to schedule a separate appointment. *A separate charge applies to these services, whether provided on the same date or a different date than the wellness visit.* We hope to help you get the most from your Medicare wellness benefits. Please contact us with any questions.

Medicare Wellness Checkup: Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health care possible.

Patient's Name:_____ Date of Birth: _____/_____/_____

Today's Date: _____ / _____ / _____

During the past month, have you had problems with:	**Yes**	**No**
70. Feeling depressed or hopeless?	___	___
71. Limited social activities due to health reasons?	___	___
72. Bodily pain?	___	___
73. Finding help when wanted or needed?	___	___

In the past month, have you had problems with:	**Yes**	**No**
74. Do light to moderate exercise?	___	___
75. Driving a car?	___	___
76. Taking public transportation?	___	___
77. Shopping for groceries without help?	___	___
78. Preparing your own meals?	___	___
79. Doing your own housework?	___	___

Do you need help with:	**Yes**	**No**
80. Eating, bathing, dressing or grooming?	___	___
81. Handling your own finances?	___	___

Do you or have you:	**Yes**	**No**
82. Feel like you are in good health?	___	___
83. Refuse to wear a seatbelt in a car?	___	___
84. Fallen 2 or more times in the last year?	___	___
85. Have a fear of falling?	___	___
86. Have an inability to exercise routinely for 20 min. at least 3 times/week?	___	___
87. Have trouble taking your medications as prescribed?	___	___
88. Lack the confidence to manage your health problems?	___	___

	Yes	**No**
89. Feel your life is **not** going well?	___	___
90. Have trouble eating well?	___	___
91. Have dental or denture problems?	___	___
92. Have problems with fatigue?	___	___
93. Have problems using a phone?	___	___
94. Have sexual problems?	___	___
95. Do you have throw rugs in the hallway?	___	___
96. Do you lack grab bars in the bathroom?	___	___
97. Have Hearing Difficulties?	___	___

Social History

Tobacco Use: Never ____ Prior Use ____ Quit Date ____/____/____
Current ____ Type _____ Frequency _____

Coffee: Cups daily ____ Other caffeine _____

Alcohol Use: No ___ Yes: ___Alcohol Use: Type _____ Amount _____

Drug Abuse: Never ____ Occasional ____ Daily ____ Prior Use ___ Quit Date ___/___/____

History of Drug Abuse (describe) _____

_____

Residence Select One:

(*Lives in own home* __) (*Lives in Adult Child's Home* __) (*Lives at Assisted Living*___)

Do you have an Advance Directive? Yes ___ No____ *If yes, your physician would like a copy of it to include in your medical chart.*

(Use a check to indicate Positive History)

	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart disease									
Stroke									
Kidney Disease									
Obesity									
Genetic Disorder									
Alcoholism									
Liver Disease									
Depression or manic depressive disorder									
Colon or rectal cancer									
Breast Cancer									
Other Cancer									
Other:									

Medical History

Hospital visits ***since*** your last office visit/reason	Facility	Attending Physician	Date of Hospital Visit

At your Medicare Wellness Visit, **please bring in all your medications** including over the counter medications, herbals and vitamin bottles, so we can update your medication list in your medical chart.

Allergy List

Allergies	Type of Reaction

Long Term Medical Problem List

Name of Long Term Medical Problem	Date of when it initially began	Name of Managing Physician (if other)

Short Term Medical Problem List

Name of Short Term Medical Problems (R=Resolved)	Date of when it Initially began	Managing Physician (it other)

Other physicians and providers of care you are presently seeing and have not mentioned above

Name & Specialty/provider type	Type of Care