St. Joseph Medical Center
St. Mary's Medical Center

Prime Healthcare Kansas City
Medicare Wellness Form

Patient Name:_____ **DOB:**_____ **Date:**_____

In order for Medicare to pay for a wellness visit and co-pay at 100% you MUST ONLY discuss wellness issues during this visit. If the Provider addresses other acute or chronic conditions during this appointment, additional charges **may** apply.

PLEASE LIST: The names of ALL doctors you are currently seeing (last 2 years)

Provider Name	Specialty	Location	Comments
	Primary Care Provider		

CIRCLE THE ANSWER THAT APPLIES

Pain Assessment

In the past 7 days have you felt pain?	YES	NO	N/A
Where is your pain located?			
Please rate your pain on a scale of 0-10 (where 0 is no pain, and 10 is the worst)_____			

Activities of Daily Living

Do you need assistance with grocery shopping, planning, and preparing?	YES	NO	N/A
Do you have trouble chewing, swallowing food, or have problems?	YES	NO	N/A
Do you need help with housework, i.e. dusting, washing dishes, vacuuming, etc?	YES	NO	N/A
Do you need help bathing or dressing?	YES	NO	N/A
Do you use any grab bars, rails or other assistive devices?	YES	NO	N/A

Functional Mobility Assessment

Do you use any of the following: Cane Walker Wheelchair?	YES	NO	N/A
Do you have any trouble getting in or out of the bathtub?	YES	NO	N/A
Do you have any trouble getting in or out of bed?	YES	NO	N/A
Do you have any trouble getting in or out of chairs?	YES	NO	N/A
Do you have any problems with making it to the bathroom on time?	YES	NO	N/A
Have you had any falls in the last 6 months?	YES	NO	N/A
Do you hold on to furniture, counters, or walls when you walk?	YES	NO	N/A
Do you have any oxygen tubing or urinary catheter?	YES	NO	N/A
Do you have a visual impairment?	YES	NO	N/A

Nutrition Assessment

Because of your health, have you had to change how you eat?	YES	NO	N/A
Do you eat fewer than 2 meals a day?	YES	NO	N/A
Do you eat few fruits, vegetables, or milk products?	YES	NO	N/A
Do you eat alone most of the time?	YES	NO	N/A
Have you lost or gained 10 pounds in the past 3 months without trying?	YES	NO	N/A
Do you ever have difficulty with shopping, cooking, and/or feeding yourself?	YES	NO	N/A
Do you take vitamins or supplements such as Calcium, Vitamin D?	YES	NO	N/A
Do you take aspirin daily?	YES	NO	N/A

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Advance Directive

Do you have an Advanced Directive?	YES	NO	N/A
Does your PCP have a copy of your Advanced Directive?	YES	NO	N/A
Do you have a copy of your Advanced Directive should you need to go to a hospital?	YES	NO	N/A

Psychosocial Assessment

Do you use alcohol?	YES	NO	N/A
How many drinks per day? _____ or per week_____			
Do you use tobacco?	YES	NO	N/A
If you are a smoker, would you like to quit?	YES	NO	N/A
Do you use street drugs and/or medications not prescribed for you?	YES	NO	N/A
Do you have any concerns about abuse or neglect	YES	NO	N/A
Are you currently sexually active?	YES	NO	N/A

Safety and Physical Activity

During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?				
Very Heavy	**Heavy**	**Moderate**	**Light**	**Very Light**
Can you handle your own money without help?			**YES**	**NO**
During the past 4 weeks, how would you rate your health in general?				
Excellent	**Very Good**	**Good**	**Fair**	**Poor**
Are you having difficulties driving your car?				
Yes - often	**Sometimes**	**No**	**N/A**	
Are you afraid of falling?			**YES**	**NO**
Do you exercise for about 20 minutes 3 or more days a week?				
Yes - most of the time	**Yes - some of the time**	**No - I do not usually exercise this much**		

How often in the past 4 weeks have you been bothered by any of the following problems:

- Fall or dizzy when standing up?	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**
- Trouble eating well?	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**
- Teeth or dentures	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**
- Problems using the phone?	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**
- Tired or fatigued?	**Never**	**Seldom**	**Sometimes**	**Often**	**Always**

Have you been given any information to help you with the following?

- Hazards in your house that might hurt you?	YES	NO
- Keeping track of your medications?	YES	NO

Vision and Hearing

Do you have any visual impairments or use visual aids such as glasses or contacts?	YES	NO	N/A
If so, which eyes?	Right	Left	Both
Last eye appointment was approximately _____ Frequency of Eye Visits?_____			
Do you have a hearing impairment or wear hearing aids?	YES	NO	N/A
If so, which ears?	Right	Left	Both
Do you have a problem hearing over the telephone?	YES	NO	
Do you have trouble following the conversation when two or more people are talking at the same time?	YES	NO	
Do people complain that you turn the TV volume up too high?	YES	NO	
Do you have to strain to understand conversations?	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	

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Vision and Hearing (continued)

Do you misunderstand what others are saying and respond appropriately?	**YES**	**NO**	
Do you have trouble understanding the speck of women and children?	**YES**	**NO**	
Do people get annoyed because you misunderstand what they say?	**YES**	**NO**	

PHQ-9 Depression Screening

In the last two weeks, have you felt little interest or pleasure in doing things?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
In the last two weeks, have you had feelings of being down, depressed, irritable, or hopeless?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Have you had trouble falling or staying asleep, or sleeping too much?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Have you been feeling tired or having little energy?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Have you had a poor appetite, weight loss, or overeating?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Have you been feeling bad about yourself – or that you are a failure and have let yourself or family down?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Trouble concentrating on things, such as reading the newspaper or watching television			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Moving or speaking slowly so 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?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**
Have thoughts that you would be better off dead, or of hurting yourself in some way?			
Not at all	**Several days**	**More than half the days**	**Nearly every day**

Patient Signature:_____ **Date:**_____

For Provider Use Only:

Advanced Care Planning Discussed?	Y	N	**Time Spent:**_____
Medications Reviewed?	Y	N	
Problem List Reviewed?	Y	N	
Surgical History Reviewed?	Y	N	
Family History Reviewed?	Y	N	
Aspirin Use Reviewed?	Y	N	
Depression Screen Administered?	Y	N	**Time Spent:**_____
Fall Risk Screen Administered?	Y	N	
Mini Cog Administered?	Y	N	

Provider Signature:_____ **Date:**_____

Family Medical Care Associates

Patient Name: _____ **DOB:**_____ **Date:**_____

Non-medical social needs, or social determinants of health (SDOH), have a large influence on an individual's health outcomes. For us to have a significant and lasting impact on the health of our patients and communities, we must address the needs of patients outside the clinic walls. To help us better care for you and achieve optimal health outcomes and whole-person care, please answer this short questionnaire. Thank you! – Family Medical Care Associates

Financial Resource Strain

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

Not hard at all	**Not Very Hard**	**Somewhat Hard**	**Hard**	**Very Hard**	**I'd rather not say**

Food Insecurity

Within the past 12 months, have you worried that your food would run out before you got money to buy more?

Never True	**Sometimes True**	**Often True**	**I'd rather not say**

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Never True	**Sometimes True**	**Often True**	**I'd rather not say**

Transportation Needs

In the past 12 months, has lack of transportation kept you from medical appointments or getting medications?

Yes	**No**	**I'd rather not say**

In the past 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living?

Yes	**No**	**I'd rather not say**

Would you like information on local resources for any of the above? *(circle all that apply)*

Yes, financial strain resources please!	**Yes, food resources please!**	**Yes, transportation resources please!**	**No, thank you!**

Social Determinants of Health (SDOH) Screening

Thank you for choosing Family Medical Care Associates for your health care needs!