Appointment Date:

Name:

Information about Annual Wellness Visits

Please Bring ALL Completed Paperwork to your visit

In recent years, Medicare has added new "Annual Wellness Visits". If you are new to Medicare, within the first 12 months, Medicare now covers a "Welcome to Medicare" visit. If you have been enrolled longer than 12 months, Medicare covers an "Annual Wellness Visit". We strongly encourage you to take advantage of these benefits as they are of NO COST to you unless other acute or chronic conditions (e.g. high blood pressure, diabetes, etc) are addressed at this visit. **If new or active chronic health problems are addressed during your visit, then it would be appropriate to bill a separate charge consistent with a regular office visit.**

Therefore, we want to make sure you are aware that Medicare Annual Wellness Visits are not "Physicals" as many of us have come to use the term. The goals are HEALTH PROMOTION and DISEASE PREVENTION. This visit is more of a conversation and counseling with a physical exam determined by your past medical and family history. It does **NOT** include addressing current or chronic conditions but DOES include:

- Counseling about preventive services, including certain screenings, shots, and referrals for other care if needed.
- A physical exam to check height, weight, blood pressure measurements and vision
- A review of your potential risk for depression and your level of safety
- An offer to talk with you about creating advanced directives (a brochure is included in your packet)
- Developing or updating a list of current providers and prescriptions
- Personalized health prevention advice
- A list of risk factors and treatment options for you
- A written plan letting you know which screenings, shots and other preventive services you may need

Medicare requires that all these elements be completed by your provider for them to pay for the visit. As you might guess, this visit takes a fair amount time with you. **PLEASE ARRIVE 30 MINUTES EARLY FOR YOUR APPT AND ALLOW FOR ONE HOUR TO BE SPENT WITH YOUR PROVIDER.** This visit gives your provider another opportunity to asses your health and get to know you better as a patient. If you have other new or active chronic problems that need to be addressed at this preventive visit, a separate charge will be applied. **We hope this clarifies this important distinction between regular and preventive office visits and billing requirements. We look forward to helping you maximize your health and quality of life!**

I understand I will be billed if new or active chronic conditions are addressed at my Annual Wellness Visit.

____________________	____________________	____________________
Printed Name	**Signature**	**Date**

GREENVINE HEALTHCARE

ESTABLISHED PATIENT ANNUAL WELLNESS QUESTIONNAIRE

Reason for today's visit:
Annual Wellness Visit
Any concerns you want to address at this visit?
Please list any other health care providers you see regularly and their specialty:

MEDICATIONS: Please list (or show us your own printed record) of all prescriptions and non-prescription medications you are taking. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter medications, etc.

Medication	Dose	How many times per day

ALLERGIES or intolerance to medications?

Medication/Food/Misc	Reaction

IMMUNIZATIONS: Enter year (if known) of any vaccinations you have received since your last exam.

Tetanus (Td)	Date:	Tetanus (Tdap)	Date:
Varicella (shot or illness)	Date:	Pneumovax (pneumonia)	Date:
Influenza (flu shot)	Date:	Hepatitis A	Date:
Hepatitis B	Date:	MMI	Date:
Meningitis	Date:	Zostavax/Shingrix (shingles)	Date:
HPV	Date:	COVID	Date:

HEALTH MAINTENANCE SCREENING TESTS you have had since your last exam

Lipid (cholesterol)	Date:	Sigmoidoscopy/colonoscopy	Date:
PSA (prostate screening)	Date:	Mammogram	Date:
PAP Smear	Date:	Bone Density Testing	Date:
Provider Reviewed Initials:		**Date:**	

PERSONAL MEDICAL HISTORY: Changes since your last physical exam			
Condition	**Yes**	**No**	**Comments**
Abnormal PAP smear			
Alcohol/Drug Abuse			
Allergies (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid/Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Blood Clot (leg/lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Location:			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Dementia			
Diabetes (adult or childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Endometriosis			
Fibroids (Uterine)			
Fractures (broken bones)			
Gallbladder Disease			
Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Heart Attack			
Hepatitis Type: A B C Other			
High Blood Pressure			
High Cholesterol			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate Enlargement or Nodules			
Seizures/Epilepsy			
Skin Issues Eczema/Psoriasis/Abnormal Moles			
Sleep Apnea			
Stomach Ulcers			
Stroke			
Thyroid Disease or Nodules			
Other:			
Other:			
Other:			
Provider Reviewed Initials:		**Date:**	

SURGICAL/PROCEDURAL HISTORY: Please check off any procedures/surgeries since your last exam		
Surgical Procedure	Year	Comments
Abdominal Surgery		
Angiogram (heart)		
Angiogram (vascular)		
Appendectomy		
Back Surgery		
Biopsy		
Breast Surgery		
Cataract Surgery		
Colonoscopy		
Coronary Bypass		
Coronary Stent		
Cesarean Section		
Echocardiogram (heart)		
EGD (stomach endoscopy)		
Gallbladder Removal		
Heart Surgery		
Hip Surgery		
Hysterectomy Partial/Complete/Total		
Joint Replacement		
Knee Surgery		
LEEP (cervix surgery)		
Neck Surgery		
Pulmonary Function Test		
Sigmoidoscopy		
Sinus Surgery		
Stress Test (cardiac)		
Tonsillectomy		
Tubal Ligation		
Vasectomy		
Other:		
Other:		
Other:		
Other:		
Other:		

HEALTH ISSUES:

Tobacco Use: Yes No If yes, please complete the following:

What do you smoke (Please circle one): Cigarettes Cigars Pipe Other:________________

How long have you been smoking: ________________ years

How much do you smoke per day: ________________ packs or each

Calculated pack history: ____________________

Alcohol Use: Yes No If yes, please complete the following:

How much do you drink?

Beer	Number per week:	________________	Bottles/Cans
Wine	Number per week:	________________	Glass/Bottles
Liquor	Number per week:	________________	Drinks/Bottles

What do you drink?

Beer	Number per week:	________________	Bottles/Cans
Wine	Number per week:	________________	Glass/Bottles
Liquor	Number per week:	________________	Drinks/Bottles

Drug Use:

Have you **ever** used illicit or legal drugs recreationally? Yes No Current use? Yes No

Which ones?: ____

Provider Reviewed Initials: **Date:**

HEALTH AND SAFETY: (Please circle one)

Does your home have working smoke detector? Yes No

Does your home have working carbon monoxide detector if gas is in the home? Yes No N/A

Do you have guns in your home? Yes No If yes, are they locked up/secured? Yes No

Have you or any family members ever been hurt, insulted, threatened or screamed at? Yes No

Do you wear a seat belt when in a vehicle? Yes No

Do you wear a helmet or protective gear when appropriate? Yes No

Do you exercise regularly? Yes No

Do you follow a special diet? Yes No Please describe if yes:

SEXUAL HISTORY:

Are you sexually active? Yes No

Sexual partners are/have been/may be in future: Female Male Both

Birth control method/sexually transmitted disease prevent: (Please circle all that apply)
None Barrier Method Pill IUD Patch Ring Diaphragm
Tubal Ligation Vasectomy Other: (specify)

WOMEN'S HEALTH:

Total # of pregnancies: Total # of births: # of miscarriages: # of abortions:

Age at the beginning or menstruation:

How often do periods occur? Every _______ days How long do they last? _________ days

How heavy are your periods? Heavy with clots Moderate Light Cramping? Yes No

Age at end of periods (menopause/hysterectomy)

Do you have concerns about your periods or menopause you'd like to discuss? Yes No

MEN'S HEALTH:

Last PSA level:

SOCIOECONOMIC:

Marital Status: (Please circle one) Single Partner Married Divorced Widow(er)

Education: High school or GED Trade school College Graduate school Other

MEDICAL FORMS:

Do you have Advance Directive for Health Care (ADHC)? Yes No

Do you have Durable Power of Attorney for Healthcare Decisions? Yes No

Do you have a Living Will? Yes No

Do you know about these or have the forms but have not completed them? Yes No

Don't know what these are? Yes No

Provider Comments after review:

Provider Reviewed Initials:	**Date:**

GREENVILLE
HEALTH CARE

Patient Name: ______________________________ DOB: __________

Physical Functional Ability Questionnaire (FAQ5)

(Please circle the number in each of the questions which best summarizes your ability)

Self-care ability assessment:

1. Require total care – for bathing, toilet, dressing, moving and eating
2. Require frequent assistance
3. Require occasional assistance
4. Independent with self-care

Family and social ability assessment:

1. Unable to perform any chores, hobbies, driving, sex, and social activities
2. Able to perform some
3. Able to perform many
4. Able to perform all

Movement ability assessment:

1. Able to get up and walk with assistance, unable to climb stairs
2. Able to get up and walk independently, able to climb one flight of stairs
3. Able to walk short distances and climb more than one flight of stairs
4. Able to walk long distances and climb stairs without difficulty

Lifting ability assessment:

1. Able to lift up to 10# occasionally
2. Able to lift up to 20 # occasionally
3. Able to lift up to 50# occasionally
4. Able to lift over 50# occasionally

Work ability assessment:

1. Unable to do any work.
2. Able to work part-time <u>and</u> with physical limitations
3. Able to work part-time <u>or</u> with physical limitations
4. Able to perform normal work.

To be completed by provider.

Physical Functional Ability Score: __________

Reviewed by provider and discussed with patient:

Provider: ______________________________ Date: __________

Revised 04/27/2023

GREENVILLE
HEALTH CARE

Patient Name: ______________________________ DOB: ____________

Patient Health Questionnaire (PHQ-(9)

(Please circle your response)

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	0	1	2	3
b. Feeling down, depressed, or hopeless	0	1	2	3
c. Trouble falling/staying asleep, sleeping too much	0	1	2	3
d. Feeling tired or having little energy	0	1	2	3
e. Poor appetite or overeating	0	1	2	3
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
h. 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
i. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	0	1	2	3

To be completed by provider.

Total Score: ____________

Reviewed by provider and discussed with patient:

Provider: ____ Date: ___________

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