Dear Patient,

As your primary health care providers, we want to help you be as healthy as possible. Medicare offers a free “PREVENTIVE” visit to assist in this goal. We want you to know about your Medicare benefits and how to get the most from them.

The terms “PHYSICAL”, “ANNUAL” or “CHECK-UP” are often used to describe a once yearly routine appointment. However, Medicare does not pay for a traditional “head-to-toe physical” or “checkup” as most people think of it. A Medicare PREVENTIVE appointment cannot include new or existing health problems.

Medicare does pay for a WELCOME TO MEDICARE PREVENTIVE visit during the first 12 months of being on Medicare and one PREVENTIVE appointment each year thereafter, to identify health risks and help you to reduce them and to discuss/order screening tests and other covered services that would be appropriate for you. We believe this appointment is a useful and worthwhile visit – and it is FREE to you!

To prepare for this important appointment, we have enclosed a comprehensive questionnaire that Medicare requires. It is imperative that you bring the completed forms with you to your appointment. During your visit, we will review the questionnaire with you. There will be a limited exam to check your height, weight, blood pressure and body mass index. You will receive a written plan of Medicare covered services/benefits and your health care provider’s recommendations

If we may provide further clarification, please do not hesitate to ask prior to scheduling your appointment.

Mountain View Family Health Care, PC

2619 Colonial Drive, Ste A • Helena, Mt59601 • Phone: 406-442-1231 • Fax: 406-442-6857

Medicare Wellness Questionnaire

Please complete the checklist before seeing your doctor or nurse practitioner. Your responses will help you receive the best health and health care possible.

Name: ________________________________ DOB:________________ Date:_______________

1. How would you describe your overall diet?

- Healthy
- High in salt
- High in fat, low in fiber
- High calories
- High carbohydrate
- Low calcium
- Other ________________

2. Have you had any of the following?

- History of fracture
- Recent explained fracture
- Sudden unexplained fracture
- Previous musculoskeletal injuries
- None of the above

3. How would you describe your physical activity?

- Exercise on a regular basis
- Recent increase in physical activity
- Good physical condition
- Decreased physical activity
- Other________________

4. During the past month have you felt any of the following?

- Sad, empty, tearful
- Loss of interest in activities
- Significant weight change
- Sleep disturbance
- Loss of energy
- Feelings of worthlessness or guilt
- Thoughts of suicide
- None of the above

5. Have you noticed significant problems with any of the following?

- Decreased concentrating ability
- Memory lapses or loss
- Forgetting words
- Writing
- Knocking over things when trying to pick them up
- None of the above

6. Do you have any difficulty with loss of hearing?

- Yes
    - Right
    - Left
- No

7. Do you have vision problems?

- Yes
    - New
    - Previously diagnosed______________
- No

8. Over the past four weeks how often have you required assistance or had difficulty with the following activities?

	Never	Seldom	Sometimes	Often	Always
Bathing					
Control urination or bowels					
Get dressed					
Feed yourself					
Get out of chair or bed					
Groom yourself					
Use the toilet					
Housework					
Grocery Shop					
Manage medications					
Manage money					
Prepare meals					
Use the Phone					

9. Have you fallen in the past year?

- Yes _______ times in the last year
- No

10. How often do you feel dizzy?

- Never
- Seldom
- Sometimes
- Often

11. Are you afraid of falling?

- Yes
- No

12. Does your home have the following?

	Yes	No
Unsafe flooring hazards (tripping risks/slip rugs/uneven floors)		
Unsafe stairs (without railings)		
Unsafe gas appliances		
Working smoke detector		
Working carbon monoxide detector		
Fire arms locked and in a safe location		
Hand bars in the bathroom/shower		
Good lighting in the home		

13. Do you wear a helmet when biking?

- Yes
- No
- Not applicable

14. Do you use seatbelts?

- Yes
- No

15. Do you practice ‘safer sex’?

- Yes
- No

16. Do you have vision or hearing loss while driving?

- Yes
- No

17. Do you have difficulties driving your car?

- Yes
- No

18. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?

- 10 or more drinks per week
- 6-9 drinks per week
- 2-5 drinks per week
- One drink or less per week
- No alcohol at all

*****If you are a new beneficiary of Medicare within the last 365 days scheduled for the “WELCOME TO MEDICARE” appointment please complete PACKET #2.***