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?

- o Yes _______ times in the last year
- o No

10. How often do you feel dizzy?

- o Never
- o Seldom
- o Sometimes
- o Often

11. Are you afraid of falling?

- o Yes
- o 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?

- o Yes
- o No
- o Not applicable

14. Do you use seatbelts?

- o Yes
- o 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 – BELOW:***

Name:____ DOB:_________________________

PERSONAL MEDICAL AND FAMILY HISTORY

Please check applicable boxes.

TOBACCO USE: ☐ None Quit Date__________

☐ Cigarettes Packs/Day______ Number of years smoked________ ☐ Pipe/Cigar

☐ Smokeless Tobacco ☐ Electronic or E-cigarette ☐ Secondhand smoke exposure

ALCOHOL USE: (please circle) None Daily Occasional Trying to Cut Down In Recovery

Amount per week:_____________________

DRUG USE: ☐None ☐Past Use ☐ Current

☐ Marijuana ☐ Amphetamines ☐ Cocaine ☐ Designer/Club

☐ Route: ☐ Smoke ☐ Inject ☐ Ingest ☐ Topical

How many times in the past year have you used recreational drugs or prescription medication for nonmedical reasons?

☐ None ☐ One or More

ADVANCE DIRECTIVE

Do you have a living Will/DNR? ☐ YES ☐ NO

Do you have a Durable Power of Attorney? ☐ YES ☐ NO

If yes:____

Please Print Name Phone Number

IMMUNIZATIONS:

Please provide any known dates or full immunization record(s).

Tetanus or Tetanus/Pertussis:___________ Influenza:____________ Shingles:____________

Meningitis____________ Hepatitis A:____________ ____________ Hepatitis B:_______________

________________ _________________ HPV:___________ _____________ ___________

Pneumovax:__________ Prevnar 13 :________________

Other:____

ALLERGIES: Known Drug Allergies: ☐ YES ☐ No

(Please add additional sheet if necessary)

Medication:___________________________ Reaction:____

Medication:___________________________ Reaction:____

Medication:___________________________ Reaction:____

Medication:___________________________ Reaction:____

Medication:___________________________ Reaction:____

Medication:___________________________ Reaction:____

Medication:___________________________ Reaction:____

Medication:___________________________ Reaction:____

Other Allergies (latex, adhesive, food, environmental)

Substance:____________________________ Reaction:____

Substance:____________________________ Reaction:____

Substance:____________________________ Reaction:____

Substance:____________________________ Reaction:____

SIGNATURE:____ **DATE:**_____________________________

(Patient or Authorized Representative)

Name:____ DOB:_____________________________

FAMILY HISTORY

What illness/conditions/diagnoses are in your family?

If known, document the age of onset in the box for the appropriate disease and family member.

	Father	Mother	Sibling(s)	Paternal Grandparent(s)	Maternal Grandparent(s)
Alcoholism/ Substance abuse					
Asthma					
Blood clots					
Breast cancer					
Colon cancer					
Prostate cancer					
Other cancer(s)					
Dementia					
Diabetes					
Heart disease					
High blood pressure					
High cholesterol					
Kidney disease					
Liver disease					
Lung disease					
Mental health/psychiatric					
Stroke					
Thyroid condition(s)					
Other					

SIGNATURE:____ DATE:____________________________

(Patient or Authorized Representative)

Patient Name:____ DOB:____________________

Please circle all that you've experienced over the LAST TWO WEEKS

General/ Constitutional	Appetite change Excessive sweating Fatigue	Fever Chills Insomnia	Night sweats Weight gain Weight loss	None
Eyes	Blurred Vision Wear corrective lenses Double vision	Dry eye Eye irritation Eye Pain	Vision loss Spots in vision	None
Ear, Nose & Throat	Ear Pain Hearing loss Tinnitus/ringing Vertigo (dizziness, balance problems) Facial pain	Bleeding gums Postnasal drainage Nose bleeds Nasal congestion Nasal drainage	Sore throat Mouth sores Hoarseness Dental pain	None
Cardiovascular	Exertional dyspnea (trouble breathing) Nocturnal dyspnea (trouble breathing)	Palpitations (irregular heartbeat) Decreased exercise tolerance	Chest pain Exertional dyspnea	None
Respiratory	Cough Sputum production Coughing up blood	Wheeze Pain with inspiration (deep breath Shortness of breath	Snoring	None
Gastrointestinal	Abdominal pain Bloating Food intolerance Nausea	Trouble swallowing Heartburn Change in bowel habits Constipation	Diarrhea Vomiting Bloody stools Black stools	None
Genitourinary	Change in urine stream Dysuria (painful urination) Hematuria (blood in urine) Incontinence	Nocturia (overnight urination) Urinary frequency Urinary retention Menstrual changes/concerns	Urinary urgency Sexual dysfunction Vaginal discharge	None
Musculoskeletal	Back pain Joint instability Joint pain Joint swelling	Limited range of motion Leg pain at night Leg pain with exertion Neck pain	Stiffness Muscle cramps Muscle weakness Muscle aches	None
Integumentary/ Skin	Hair changes Lesions/changes in moles Breast masses	Pigment changes Rash Pruritus/persistent itch	Psoriasis	None
Neurologic	Abnormal gait/walking Focal weakness Headache(s) Confusion Memory problems	Seizures Decreased sensation Balance problems Restless legs Other neurologic concern	Speech problems Twitches/spasms Tremor Tingling Numbness	None
Psychiatric	Anxiety Decreased concentration Irritability Suicidal thoughts	Thought of hurting others Panic attacks Insomnia Mood swings	Sadness/tearfulness Depression Excessive sleep Hallucinations	None
Endocrine	Cold intolerance Heat intolerance	Excessive thirst Excessive hunger	Excessive urination	None
Hematologic/ Lymph	Bruising tendency Bleeding tendency	Swollen glands Recurrent infections		None
Allergy/ Immunologic	Eczema Immunocompromised	Seasonal allergies Hives/Urticaria		None
Any other symptoms:				

SIGNATURE:____ DATE:____________________________

(Patient or Authorized Representative)

Patient Name:____ **DOB:**____________________

Your Care Team (other health care providers)
Provider: ___________________________ **Specialty:**__________________ **Phone:**______________
Provider: ___________________________ **Specialty:**__________________ **Phone:**______________
Provider: ___________________________ **Specialty:**__________________ **Phone:**______________

Procedures (list year):
Colonoscopy:_________ **Sigmoidoscopy:**_________ **Stress Test:**__________ **EKG:**__________
Mammogram:_________ **DEXA Scan:**_____________

Please list any hospitalizations excluding surgeries/procedures

Hospitalized for	Year

Surgical History **Please list surgeries/procedures and add notes as needed other than listed above**

YEAR	Surgery/Procedure	Hospital/Location	Complications/Additional Comments

MEDICATIONS: ☐ **None** **(please list any medications you are taking (including aspirin, vitamins and supplements), dosage, and how often you take them)**

Current Medications

Name of Medication	Dose	How often do you take	Reason for taking medication

PREFERRED PHARMACY

Local:________________________ **Mail Order:**____

SIGNATURE:____ **DATE:**_____________________________
(Patient or Authorized Representative)