Nature Coast Health Care

Medicare Annual Wellness Questionnaire

Name:_____ Date of Birth: _____Date:_____

Please check the appropriate box that answers the questions below and write any additional pertinent information that will help us meet your needs better.

What is your primary language? O English O Spanish Other: _____

Where do you currently live?
O Live in an independent house, apartment, mobile home
O Live in an assisted living apartment, or board & care: Name: _____
O Live in a nursing home: Name: _____
O Other (Describe):_____

What is your current living arrangement? (Check each that applies)
O Live alone
O With spouse/significant other
O With child(ren)
O With other relative(s)
O With non-relative(s)
O With paid caregiver

Do you plan on changing your present living arrangements in the next 6 months?
O Yes O No If yes, describe: _____

Are you under the care of a Specialist? O Yes O No
If yes, list Name(s) & specialty? _____
_____

Have you been to the Emergency Room in the past 6 months?
O Yes, how many times: _____ O No

Have you stayed overnight in the hospital in the past 12 months?
O Yes, how many times: _____ O No

Have you been in a Skilled Nursing Facility in the past 12 months?
O Yes, how many times: _____ O No

In general, would you say your health is: (Check one answer)
O Excellent O Very Good O Good O Fair O Poor

Do you need assistants doing any of the following?

	Yes	No
Using the toilet	O	O
Bathing	O	O
Dressing	O	O
Eating	O	O
Getting in/out of bed or chairs	O	O
Walking	O	O
Managing Money	O	O
Taking Medications	O	O
Preparing Meals	O	O
Shopping and Errands	O	O
Housekeeping Chores	O	O
Using the Telephone	O	O

If you receive help with any of the activities selected in above question, who is the helper? (Name, relationship and phone number if we may contact your helper)

_____

Name Relationship Phone Number

Do you use any of the following special equipment because of disability or health problem?

	Yes	No
Walker	O	O
Bedside Commode	O	O
Wheelchair	O	O
Hoyer Lift	O	O
Cane	O	O
Grab Bars	O	O
Bath Bench	O	O
Hospital bed	O	O
Ramps	O	O
Raised Toilet Seat	O	O

Do you have Diabetes? O Yes O No
If yes, have you had your Diabetic Eye Exam done in the past year? O Yes O No

Do you have regular dental checkup? O Yes O No
If your answer is yes, when was your last appt? _____
If no, please explain why? _____.

Are you currently receiving any of the following services from an agency?

	Yes	No
Home Health Nurse	O	O
Physical, Occupational, Speech Therapy	O	O
Home Health Aide	O	O
Social Worker	O	O

Adult Day Care Center	O	O
Assistance with Transportation	O	O

Other: _____

Do you currently use or receive any of the following?

	Yes	No
Feeding Tube	O	O
Oxygen	O	O
Colostomy Care	O	O
Catheter Care	O	O

Other: _____

Which of the following statements fits you best in terms of health? Check all that apply.

O Must stay in bed all or most of the time because of physical limitations
O Must stay in the house all or most of the time because of physical limitations
O Need the help of another person in getting around inside or outside the house
O Need the help of some special aid, like a cane/wheelchair to get around inside or outside the house
O Do not need the help of another person or a special aid but have trouble getting around freely
O Not limited in any of these ways

Do you need help at home because of health problems and are unable to get help? O Yes O No

Have you completed an Advance Directive? O Yes O No
(A document that directs your health care wises in the event you become ill)

If yes, is it on file with our office O Yes O No
If no, are you interested in receiving information on Advance Directive? O Yes O No

Have you fallen in the last 12 months? O Yes O No

Do you have any wounds, sores or skin breakdown? O Yes O No
If yes, please describe:_____

Do you currently have any pain? O Yes O No
If yes, describe: _____
Pain severity Scale: 1-10 (10 being the most severe):_____
Do you take medicine for pain? O Yes O No
If yes, name of Medicine(s):_____

Does the pain medicine provide adequate relief of your pain?
O All the time O Most of the time O Some of the time O None of the time

Do you feel depressed? O Yes O No
If yes, are you currently being treated for depression? O Yes O No

Do you feel you have a problem with:

Alcohol Abuse O Yes O No

Drug Abuse O Yes O No

Do you smoke? O Yes O No

If yes, are you interested in a Smoking Cessation Program? O Yes O No

Do you routinely get a flu shot every year? O Yes O No O Unknown

Have you had a pneumonia shot in the past? O Yes O No O Unknown

Have you had a test to screen for colon cancer done with one of the following?
FOBT (Fecal Occult Blood Test), testing the stool for presence of blood this year?

O Yes O No O Unknown

Colonoscopy anytime in the last 10 years? O Yes O No O Unknown

Are you a caregiver? (For a spouse or someone else) O Yes O No

Is there a friend, relative or neighbor who would take care of you for a few days, if necessary?

O Yes O No

If yes, name, relationship, and day phone of the person who could care of you?

_____ _____ _____

Name Relationship Phone Number

Is there anything else you would like us to know about you? _____
_____
_____
_____

_____ _____

Patients Signature **Date**

<u>To be completed by office staff:</u>

Weight_____ Height_____ BMI_____ BP_____

Include referrals to programs aimed at:

- Community-based lifestyle interventions to reduce health risks and promote self-management and wellness
- Weight loss
- Physical activity
- Tobacco-use cessation
-Fall prevention
- Nutrition

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List of Providers

Patient Name:_____ Date of Birth:_____

Please list all physicians you are currently being treated by or have seen in the last 2 years.

Physician Name/Specialty Address/Phone Number Last Seen

_____

_____

_____

_____

_____

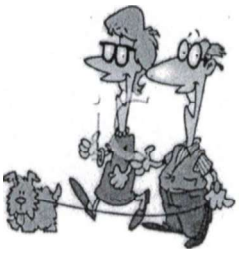
_____

_____

_____

_____

"Get Up and Go"



Name: _____DOB:_____
Date:_____

Questions 1-6 to be completed by the Patient	**Yes**	**No**
1. Have you fallen or had problems with balance or walking in the last 12 months?	☐	☐
a. How many times have you fallen? _____		
b. Date last fall occurred: _____		
c. Were any medications started or medications changed around the time of this fall? If yes, please list: _____		
2. Circumstances of fall:		
a. Lightheadedness/palpitations	☐	☐
b. Loss of consciousness	☐	☐
c. Tripped/stumbled over something? If yes, explain: _____	☐	☐
d. Unable to get up within 5 minutes	☐	☐
e. Needed assistance to get up	☐	☐
3. Do you have any assistive devices? (cane, walker, wheelchair, other) Please specify: _____	☐	☐
a. Were you using it when you fell?	☐	☐
4. Any recent vision changes?	☐	☐
5. Any recent hearing changes?	☐	☐
6. Any problems holding your urine or having incontinence that is bothersome?	☐	☐

Questions 7-9 to be completed by the Medical Assistant:

***Note: If answers to questions 1-6 are "NO", complete question 7 ONLY**

7. Get Up and Go Test: # Seconds _____

(Person may wear their usual footwear and use any assistive device normally used)
-Have patient sit in standard chair with their back to the chair and arms resting on arm rests.
-Ask patient to stand up and walk 10 ft, turn around, walk back to their chair and sit down again.
-Timing begins when patient starts to rise from chair and ends when they return to chair and sit down.
The patient should have 1 practice trial and then 3 actual trials. Times from the actual trials are averaged.

Seconds Rating
<10 Freely Mobile
<Mostly independent
20-29 Variable mobility
>30 Impaired mobility

8. Eye Exam:

a. Is eye exam in the chart in the past year Y / N (circle one)
b. If not in chart or patient had recent vision changes, perform Snellen eye chart test:
Left Eye (OS): 20/____ Right Eye (OD): 20/____ Both Eyes (OU): 20/ ____

9. Blood Pressure

a. If yes to either **2a** or **2b above,** take orthostatic BP and record results in progress note.

Name: _____ ***Date:*** _____

DOB: _____

Patient Health Questionnaire (PHQ–9)

1. Over the last two weeks how often have you been bothered by any of the following problems?

	Not at all (0)	**Several days** (1)	**More than half the days** (2)	**Nearly every day** (3)
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	☐	☐	☐	☐
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 more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

Total Score: _____

2. If you checked off <u>any</u> problem on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

_____ _____

Patient/Guardian Signature *Date*