To: Our Medicare Patients

Subject: Your Welcome to Medicare Exam

Medicare covers a one-time “Welcome to Medicare” visit. The “Welcome to Medicare” visit must occur during your first twelve months as a Medicare patient. This visit is only for new Medicare patients and must be performed within the 1st year as a Medicare patient.

The “Welcome to Medicare” visit is not the same thing as what many people often refer to as their yearly physical exam. Medicare is very specific about what the “Welcome to Medicare”, appointment includes and excludes.

At the “Welcome to Medicare” visit your doctor will review your medical history, screen you for depression, and determine your functional ability and level of safety. You will be provided with a personalized prevention plan to help keep you healthy. The visit does not include a comprehensive physical exam, discussion or testing regarding any new or current medical problems, conditions or medications. You may schedule another visit to address those issues or your doctor may charge the usual Medicare fees for such services that are beyond the scope of the Welcome to Medicare visit.

We encourage you to be familiar with your insurance policy and coverage. Please refer to the following code when discussing coverage with your insurance provider

Welcome to Medicare = G0402

Please bring the following to your appointment:

- Your insurance card(s)
- Completed questionnaire enclosed with this letter
- Your prescription medication and over-the-counter medication bottles including vitamins and supplements
- Immunization records
- Copies of Advance Directives – forms can be found on the ProHealth Care website: ProHealthCare.org/AdvanceDirectives

We look forward to seeing you. Thank you for choosing ProHealth Care for your health care needs.
Welcome to Medicare Pre-Visit Questionnaire - Female

Please circle your answers to the questions below:

END OF LIFE PLANNING

1. Do you have a current Advance Directive, Living Will or Power of Attorney for Health Care?  
   Yes  No

2. Who makes your health care decisions?  
   Self  Sibling  Guardian  Health care agent  Other

3. If you do not have an Advance Directive, would you like information/assistance to create one?  
   Yes  No

DIET

1. Do you eat fruit and/or vegetables every day?  
   Yes  No

2. Do you limit your salt intake?  
   Yes  No

PHYSICAL ACTIVITY

1. Do you usually exercise at least 30 minutes or more, 4 days a week?  
   Yes  No

HEPATITIS B RISK

1. Does anyone in your household have hepatitis B?  
   Yes  No

2. Do you currently use or have you ever used intravenous drugs?  
   Yes  No

3. Do you work in healthcare?  
   Yes  No

4. Do you require repeated blood or blood product transfusion?  
   Yes  No

5. Do you have liver disease?  
   Yes  No

6. Do you have diabetes?  
   Yes  No

7. Are you planning to spend more than 6 months, live in a rural area, or have close physical or sexual contact with the local population outside North America, Western Europe or Australia?  
   Yes  No

8. Have you had a hepatitis B vaccination?  
   Yes  No

HEPATITIS C RISK

1. Were you born between 1945 – 1965?  
   Yes  No

2. Have you had a blood transfusion before 1992?  
   Yes  No

3. Have you ever had a hepatitis C test?  
   Yes  No

STD SCREENING

1. In the past 12 months, have you had more than one sexual partner?  
   Yes  No

This form is a worksheet only, and will not become part of the legal medical record. All information from worksheet should be entered into EMR electronically.
Welcome to Medicare Pre-Visit Questionnaire - Female

**HIV TESTING**
1. Have you ever had an HIV or AIDS test?  Yes  No

**ALCOHOL & DRUG USE**
1. How many times in the past year have you had 4 or more drinks in a day?  
   0  1  2  3  4  5  6+
2. How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? For example, because of the experience or feeling it caused.  
   0  1  2  3  4  5  6+

**BOWEL/BLADDER CONTROL**
1. Do you have difficulty controlling your urine or bowel movements?  Yes  No

**ACTIVITIES OF DAILY LIVING**
Do you need help with any of the following?
1. Bathing  Yes  No
2. Dressing  Yes  No
3. Using the toilet  Yes  No
4. Eating  Yes  No

**FALLS RISK**
1. Do you have difficulty moving in or out of bed or chairs?  Yes  No
2. Do you have difficulty with walking or balance?  Yes  No
3. Have you had 2 or more falls in the last 12 months?  Yes  No

**HOME SAFETY**
1. Have you completed a home safety evaluation?  Yes  No

**GLAUCOMA SCREENING**
1. Do you have a family history of glaucoma?  Yes  No
2. Are you over age 50 and of African-American descent?  Yes  No
3. Are you over age 65 and of Hispanic-American descent?  Yes  No

**HEARING IMPAIRMENT**
1. Do you have difficulty with your hearing?  Yes  No

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Welcome to Medicare Pre-Visit Questionnaire - Female

ABDOMINAL AORTIC ANEURYSM

1. Do you have a family history of abdominal aortic aneurysm? Yes No
2. Have you ever been screened for abdominal aortic aneurysm? (usually done with an abdominal ultrasound) Yes No

DEPRESSION SCREENING

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things?
   Not at all   Several days   More than half the days   Nearly every day
   0           1               2                             3

2. Feeling down, depressed or hopeless?
   Not at all   Several days   More than half the days   Nearly every day
   0           1               2                             3

3. Trouble falling or staying asleep, or sleeping too much?
   Not at all   Several days   More than half the days   Nearly every day
   0           1               2                             3

4. Feeling tired or having little energy?
   Not at all   Several days   More than half the days   Nearly every day
   0           1               2                             3

5. Poor appetite or overeating?
   Not at all   Several days   More than half the days   Nearly every day
   0           1               2                             3

6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down?
   Not at all   Several days   More than half the days   Nearly every day
   0           1               2                             3

7. 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
   0           1               2                             3

8. 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?
   Not at all   Several days   More than half the days   Nearly every day
   0           1               2                             3

9. 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
   0           1               2                             3

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