To: Our Medicare Patients

Subject: Your Medicare Annual Wellness Visit

Medicare covers a Medicare Annual Wellness Visit every year. You may receive an Annual Wellness visit after you have been with Medicare for more than one year, or it has been at least one year since your "Welcome to Medicare" visit. These are covered yearly as long as it has been at least 366 days since your previous Medicare Annual Wellness Visit.

An Annual Wellness 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 Annual Wellness Visit includes and excludes.

At the Annual Wellness Visit your doctor will review your health risk assessment, your current medical providers and medical history, screen you for depression and memory loss, and determine your functional ability and level of safety. You will be provided with a personalized prevention plan to 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 fess for such services that are beyond the scope of the Medicare Annual Wellness visit.

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

First Annual Wellness visit = G0438
Subsequent Annual Wellness visit = G0439

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.

Annual Wellness Visit Pre-Visit Questionnaire - Male

Name _____

Date of birth _____

Please circle your answers to the questions below:

DEMOGRAPHIC DATA

1. What is your race?
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Native Hawaiian or Other Pacific Islander
   - Other
   - Prefer not to answer
   - Unknown
   - White or Caucasian

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

CURRENT PROVIDERS

Please list your current health care providers below.

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HEALTH STATUS

1. In general, would you say your health is:
   Excellent Very good Fair Poor

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.

Annual Wellness Visit Pre-Visit Questionnaire - Male

DIET

1. Do you eat fruit and/or vegetables every day? Yes No
2. Do you limit your salt intake? Yes No
3. Do you routinely eat fatty fish such as salmon or tuna or take a vitamin D supplement containing at least 800 IUs of vitamin D per day? 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. Do you have sex with other men? Yes No
2. Does anyone in your household have hepatitis B? Yes No
3. Do you currently use or have you ever used intravenous drugs? Yes No
4. Do you work in healthcare? Yes No
5. Do you require repeated blood or blood product transfusion? Yes No
6. Do you have liver disease? Yes No
7. Do you have diabetes? Yes No
8. 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
9. 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

HIV TESTING

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

Annual Wellness Visit Pre-Visit Questionnaire - Male

ALCOHOL & DRUG USE

1. How many times in the past year have you had 5 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

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

1. Can you travel alone by bus, taxi, or drive your own car? Yes No
2. Can you shop for groceries or clothes without help? Yes No
3. Can you prepare your own meals? Yes No
4. Can you handle your own money without help? Yes No
5. Do you have enough money to afford your medications, groceries and day-to-day bills? Yes No
6. Can you do your own housework without help? Yes No
7. Are you being abused or neglected? Yes No

PSYCHOSOCIAL RISKS

1. Is there someone available to help you if you needed and wanted help? Yes No

Annual Wellness Visit Pre-Visit Questionnaire - Male

FALLS RISK

1. Do you have difficulty moving in or out of beds 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

VISION

1. Have you had a general eye exam within the last 2 years? Yes No

HEARING IMPAIRMENT

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

PROSTATE CANCER SCREENING

1. Are you Black or African-American descent? Yes No
2. Did your grandfather, father, uncle, brother or son have prostate cancer? Yes No

ABDOMINAL AORTIC ANEURYSM

1. Have you smoked at least 100 cigarettes in your lifetime? Yes No
2. Do you have a family history of abdominal aortic aneurysm? Yes No
3. 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

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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

10. Have you ever taken medication or received counseling for depression, anxiety or any other mood disorder? Yes No

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