***WELCOME TO MEDICARE PATIENT QUESTIONNAIRE***

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| **NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE : \_\_\_\_\_\_\_****Medicare Eligibility Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

*Preventive screenings and services, early detection of disease, and disease management, along with professional advice on diet, exercise, weight control, and smoking cessation, can help beneficiaries lead healthier lives and prevent, delay, or lessen the impact of disease. The Centers for Medicare & Medicaid Services (CMS) continues with its initiative to help Medicare beneficiaries lead healthier lives through a comprehensive health care program, and to make Medicare a prevention-focused program.*

**A Message for our Patients**:

This questionnaire is intended to help your provider offer the highest standard of care as you begin your Medicare enrollment. The purpose is to determine if you have a problem which may need further evaluation and welcome you to the services offered by Medicare Part B. Additionally, the questionnaires are a required component of performing and billing the “Welcome to Medicare Physical”\* and/or Medicare Annual Wellness Visit. We ask that you fill out the questionnaires and your provider will evaluate your answers and talk with you about any findings that may require further evaluation. If you need help or have questions about any of these screenings, please talk to your provider.

Thank you for your cooperation,

**Whole Life Health Care Providers**

\*THIS DOES NOT TAKE THE PLACE OF YOUR YEARLY WELLNESS PHYSICAL

**Screening for Depression**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Over the last two weeks, how often have you been bothered by the following problems?** |  | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
| 1. Little interest or pleasure in doing things
 |  |  |  |  |  |
| 1. Feeling down, depressed, or hopeless
 |  |  |  |  |  |
| 1. Trouble falling or staying asleep, or sleeping too much
 |  |  |  |  |  |
| 1. Feeling tired or having little energy
 |  |  |  |  |  |
| 1. Poor appetite or overeating
 |  |  |  |  |  |
| 1. Feeling bad about yourself—or that you are a failure or have let yourself or your family down
 |  |  |  |  |  |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television
 |  |  |  |  |  |
| 1. 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
 |  |  |  |  |  |
| 1. Thoughts that you would be better off dead, or of hurting yourself in some way
 |  |  |  |  |  |

If you checked off any problems, how difficult 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
* Provider Assessment: No further Evaluation Needed
* Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Functional Activities Questionnaire**

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| --- |
|  **Please circle YES or NO** |
| 1. **Do you live alone?**
 | **YES** | **NO** |
| 1. **Can you get out of bed by yourself?**
 | **YES** | **NO** |
| 1. **Are you able to shower/bathe without help?**
 | **YES** | **NO** |
| 1. **Can you dress yourself without help?**
 | **YES** | **NO** |
| 1. **Are you able to do your own shopping?**
 | **YES** | **NO** |
| 1. **Are you able to prepare your own meals?**
 | **YES** | **NO** |
| 1. **Are you able to manage your financial situation?**
 | **YES** | **NO** |
| 1. **Are you able to take your medications according to directions?**
 | **YES** | **NO** |
| 1. **Can you keep track of appointments and family occasions?**
 | **YES** | **NO** |
| 1. **Do you have difficulty with transportation away from home?**
 | **YES** | **NO** |
| 1. **Have you or your family/friends noticed: forgetfulness, poor mental function, confusion, or difficulty concentrating?**
 | **YES** | **NO** |

* Provider Assessment: No further Evaluation Needed
* Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Safety Questionnaire**

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| --- |
|  **Please circle YES or NO** |
| 1. **Do you have throw rugs in your house?**
 | **YES** | **NO** |
| 1. **Do you have furniture with sharp corners or a rickety**

**chair that could cause injury?**  | **YES** | **NO** |
| 1. **Does your home have poor lighting?**
 | **YES** | **NO** |
| 1. **Do you have nightlights in your house?**
 |  |  |
| 1. **Do you have pets that stay indoors?**
 | **YES** | **NO** |
| 1. **Does your home have functional smoke alarms**

**and carbon monoxide detectors?** | **YES** | **NO** |
| 1. **Does your bathtub have safety measures like a**

**rubber mat or safety bars?** | **YES** | **NO** |
| 1. **Is the area in front of your tub carpeted or protected**

**by a non-slip mat?** | **YES** | **NO** |
| 1. **Does your home have hand rails on stairs and steps?**
 | **YES** | **NO** |
| 1. **Do you have frayed cords or overloaded electrical**

**sockets in your house?** | **YES** | **NO** |
| 1. **Does your home have a working telephone?**
 | **YES** | **NO** |

* Provider Assessment: No further Evaluation Needed
* Advice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Screening for Hearing Loss**

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| --- |
| **Please circle YES or NO** |
| 1. **Do you have trouble hearing over the telephone?**
 | **YES** | **NO** |
| 1. **Do you have trouble hearing the television or radio?**
 | **YES** | **NO** |
| 1. **Do you have to strain/struggle to understand conversations?**
 | **YES** | **NO** |
| 1. **Do you find yourself asking people to repeat themselves?**
 | **YES** | **NO** |
| 1. **Do you misunderstand what others say or respond inappropriately?**
 | **YES** | **NO** |
| 1. **Do you have trouble hearing in a noisy back ground?**
 | **YES** | **NO** |

* Provider Assessment: No further Evaluation Needed
* Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screening for Risk for Falls**

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| --- |
| **Please circle YES or NO** |
| 1. **Have you ever fallen in the past?**
 | **YES** | **NO** |
| 1. **Do you have any difficulty when walking?**
 | **YES** | **NO** |
| 1. **Do you ever lose your balance with movements such as**

**bending over, or turning around etc.?** | **YES** | **NO** |
| 1. **Do you notice numbness in your feet?**
 | **YES** | **NO** |
| 1. **Do you have difficulty getting out of a chair?**
 | **YES** | **NO** |
| 1. **Do you ever feel lightheaded upon rising from a seated position?**
 | **YES** | **NO** |
| 1. **Do your steps feel heavy when you walk or trip frequently?**
 | **YES** | **NO** |

* If the above answers represent risk of falling, perform the Get Up and Go test
* Provider Assessment :  Evaluation Needed  Get up and Go Test Performed

**Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WELCOME TO MEDICARE PE GUIDE FOR THE PROVIDER\***

**(\*Patients, Please Fill Out Questions 1-4 ONLY)**

* **Focused Physical Exam**
	+ Height, Weight, BMI, Blood Pressure
	+ Visual Acuity Screening
* **Advanced Care Planning**

|  |  |  |
| --- | --- | --- |
| 1. **Do you agree to give verbal consent to discuss end of life issues with healthcare provider?**
 | **YES** | **NO** |
| 1. **Have you already executed an Advance Directive?**
 | **YES** | **NO** |
| **(If NO to #2, was patient given the opportunity to execute as Advance Directive today?)** | **YES** | **NO** |
| 1. **List current Health Care Providers:**
 |  |  |
| 1. **List current suppliers of medical equipment:**
 |  |  |
|  |
| 1. **Provider has completed an order for life sustaining treatment, or similar documentation YES NO**

 **of reflecting the patient’s wishes for and advanced care plan?** |
| 1. **Provider is willing to follow the patient’s wishes for the above advanced directives?**
 |  **YES** | **NO** |

* **Performance and Interpretation of EKG**
	+ ICD-9: ^0366-G0368
* **Brief education, counseling, referral to address pertinent health issues identified during exam**
	+ Amount of time spent counseling patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Brief education, counseling, referral, with maintenance of written plan regarding separate preventative care services covered by Medicare Part B**

**Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_**