Southside
Medical Management

A WORD TO OUR PATIENTS ABOUT MEDICARE AND WELLNESS CARE

Dear Patient,

We want you to receive wellness care – health care that may lower your risk of illness or injury. Medicare pays for some wellness care, but it does not pay for all the wellness care you might need. We want you to know about your Medicare benefits and how we can help you get the most from them.

The term "physical" is often used to describe wellness care. But Medicare does not pay for a traditional, head-to-toe physical. Medicare *does* pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:

- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- Recommendations for other wellness services and healthy lifestyle changes.

Before your appointment, our staff will ask you some questions about your health and may ask you to fill out a form.

A wellness visit does not deal with new or existing health problems. That would be a separate service and requires a longer appointment. Please let our scheduling staffs know if you need the doctor's help with a health problem, a medication refill or something else. We may need to schedule a separate appointment. *A separate charge applies to these services, whether provided on the same date or a different date than the wellness visit.*
We hope to help you get the most from your Medicare wellness benefits.

Please contact us with any questions.

Southside Medical Management

PATIENT NAME:_____

DOB:_____/_____/_____

PERSONALIZED PREVENTION PLAN OF SERVICE

PREVENTATIVE TEST	RECOMMENDED	LAST RECEIVED	DUE
Welcome to Medicare (IPPE)	Within 1st 12 mo		
Yearly Wellness Exam (AWV)	Every 1yr		
EKG Screening	Once in lifetime (at IPPE, cost associated)		
Colonoscopy	Every 10 years or based on risk		
Fecal Occult Blood Test	Every 1yr		
Cholesterol Screening	Every 5 years		
Diabetes Screening	Pre-dm – 2x yr Non dm – once yr		
Glaucoma Screening	Every 1 yr		
Depression Screening	Every 1 year		
Influenza Vaccination	Every 1 year		
Pneumonia Vaccination	Once in lifetime		
FEMALES ONLY			
Pelvic Exam/Pap Smear	High risk – every 1 yr; low risk – every 2 yrs		
Mammogram	Every 1 year		
MALES ONLY			
Prostate Exam/PSA	Every 1 year		
AT RISK			
AAA Screening	Once in lifetime		
Bone Density Test	Every 2 yr		
HIV Screening	Risk based		
Tobacco Cessation	Up to 8 sessions/1 yr		
STI Screening	Risk based		
Nutrition Therapy	1st yr 3 hours, 2 hours after 1st yr		
Hepatitis B Vaccination	Risk based		
Diabetes DSMT	1st yr 10 hrs, then 2 hrs thereafter yearly		
Flexible Sigmoidoscopy	Every 4 yrs or 120 mo after previous screening colonoscopy for not at risk		
Barium Enema	(as alt to flex sig) every 48 mo or 24 mo for high risk		

COMMENTS:

_____

_____

_____

REVIWED BY: _____**DATE:**_____

WELLNESS HEALTH RISK ASSESSMENT

Patient Name:_____ **Date:**_____

DOB:____/____/_____ Medicare B Eligibility Date: ____/____/_____

ALLERGY LIST (cont. on back)	
ALLERGIES	**TYPE OF REACTION**

MEDICATION LIST (cont. on back)	
MEDICATIONS,HERBALS, VITAMINS, SUPPLEMENTS	**DOSAGE**

MEDICAL HISTORY (cont. on back)		
CHRONIC PROBLEMS	**DATE STARTED**	**MANAGING PHYSICIAN**

SURGICAL HISTORY (cont. on back)		
SURGERIES	**DATE OCCURED**	**SURGEON**

HOSPITALIZATIONS (cont. on back)		
HOSPITAL VISITS SINCE LAST VISIT/REASON	**DATES**	**MANAGING PHYSICIAN/ HOSPITAL**

OTHER PHYSICIANS (cont. on back)	
PROVIDER/SPECIALTY	**TYPE OF CARE**

DEPRESSION SCREENING		
1. Do you feel down, depressed or hopeless?	**YES**	**NO**
2. Do you feel little interest or pleasure in doing things?	**YES**	**NO**

FUNCTIONAL ABILITY/SAFETY SCREENING		
1. Does it take you longer than 30 sec to get up and get steady?	**YES**	**NO**
2. What is the hardest physical activity you can do for at least 2 minutes? very heavy heavy moderate light very light		
3. Can you get to places out of walking distance without help? (for example: travel alone on a bus/plane/taxi, drive your own car? YES NO		
4. Do you drive?	**YES**	**NO**
5. Do you wear a seatbelt?	**YES**	**NO**
6. Have you fallen 2 or more times in the past 1 year?	**YES**	**NO**
7. Do you have in your home: throw rugs grab bars in bathroom handrails along stairs areas with poor lighting functional fire alarms		
8. Do you need help with: phone transportation shopping preparing meals housework laundry medications managing money grooming/dressing (check all that apply)		
9. Do you have someone available to help you if needed?	**YES**	**NO**
10. Do you have trouble with your memory?	**YES**	**NO**
11. Do you have hearing difficulties?	**YES**	**NO**
12. Do you feel safe in your living environment?	**YES**	**NO**
13. How much bodily pain do you have? none very mild mild moderate severe		

SOCIAL HISTORY	
TOBACCO USE:	**_____per day _____ years _____quit date**
ALCOHOL USE:	**daily _____ weekly_____ socially past use _____quit date**
DRUG USE:	**yes _____type no past _____ quit date**
OCCUPATION:	
MARITAL STATUS:	**Single Married Divorced Widowed**
CHILDREN:	**#_____**
HOME ENVIRONMENT:	**WHO DO YOU LIVE WITH?_____**
DO YOU HAVE:	**LIVING WILL/ADVANCED DIRECTIVES POWER OF ATTORNEY NONE**
DIET HABITS:	**CAFFEINE DESCRIBE TYPICAL DIET:**
EXERCISE:	**TYPE:_____FREQUENCY:_____**

FAMILY HISTORY Use √ to indicate positive history (cont. on back)									
	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart disease									
Stroke									
High Cholesterol									
Diabetes									
Kidney disease									
Obesity									
Genetic disorder									
Alcoholism									
Liver disease									
Depression or manic depressive disorder									
Colon or rectal cancer									
Breast cancer									
Other cancer _____									
Other: _____									
Other: _____									
Other: _____									
Other: _____									
Other: _____									

REVIEWED BY:_____DATE:_____