MEDICARE ANNUAL WELLNESS VISIT

We are excited to announce that Medicare now covers a free annual wellness visit. Co-pays and deductibles do not apply for the visit but may be associated with some of the studies recommended at this visit. The annual wellness visit is different from a traditional routine physical because it screens for risks specific to the senior population (such as fall risk, worsening memory, and depression). This is the only preventive visit that Medicare will reimburse. We ask, therefore, that this visit be limited to developing your personalized prevention plan, a written list of tests and interventions that your provider recommends specifically for you. If you do have a more urgent concern, we request that you schedule a separate appointment to address this. Co-pays and deductibles will apply for any care that is not part of the annual wellness visit.

To make this visit as helpful as possible, please complete the attached Annual Wellness Visit form before your appointment and make sure to bring it with you along with a list of your medications and other providers of care. Please bring in documentation of your vaccines and any other screening tests that you may have had if not done here. Also bring in copies of any advanced directives or medical durable power of attorney forms.

We look forward to seeing you soon for your annual wellness visit! Call us today at 281-342-6006 to schedule your appointment.

Sincerely,

The Providers and Staff of South Texas Medical Clinics, P.A.

Patient Name:__________________________
Date: __________________________

ANNUAL WELLNESS VISIT

1. Past Medical History: Please circle any of the following that you have or have had in the past.

____Cataracts
____Glaucoma
____Impaired vision
____Macular degeneration
____Hearing loss
____Ringing in the ears
____Nose bleeds
____Sinus problems
____Difficulty swallowing
____High blood pressure
____Heart disease
____Heart attack
____Heart failure
____Atrial fibrillation
____Valve problems
____Aneurysm
____Carotid disease
____Peripheral vascular disease
____Pacemaker
____Defibrillator
____Asthma
____COPD
____Persistent cough
____Sleep Apnea
____GERD/acid reflux
____Gallbladder surgery
____Chronic constipation
____Ulcer
____Diverticulosis
____Blood in stool
____Black-colored stool
____Bowel Obstruction
____Hysterectomy
____Incontinence
____Enlarged Prostate
____Osteoporosis
____Osteopenia
____Fibromyalgia
____Weakness of arms/legs
____Gout
____Diabetes
____High cholesterol
____Thyroid disorder
____Vitamin D deficiency
____Frequent bladder infections
____Kidney stones
____Stroke or mini-stroke
____Dementia
____Seizures
____Parkinson's
____Neuropathy
____Arthritis
____Hot flashes
____Chronic kidney disease
____EPOGEN injections
____Anemia
____B12 deficiency
____Tattoo
____Blood transfusion
____Skin Infections
____Rash
____Shingles
____Cancer, type__________________

2. Please list any major surgeries that you have had.

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3. Please list all medications (including over-the-counter and supplements), the dose, and how often you take them. Use separate sheet if needed.

4. Please list any other health care providers whom you see and why you are seeing them. Also include suppliers of medical equipment (CPAP machine, oxygen) and home health services.

5. Are you allergic to any medications or foods? If so, please list the reaction.

6. Do you feel that you have a well-balanced diet?

7. Do you exercise?

8. Are you a current or former smoker? If so, list how many packs/day and for how many years. Also list approximate quit date, if applicable.

9. How many alcoholic beverages do you consume per week?

10. Have you ever used illegal drugs?

11. Do you have any concerns about your memory?

12. Over the past two weeks, have you felt down, depressed or hopeless?

13. Over the past two weeks, have you felt little interest or pleasure in doing things?

14. Who lives with you in your home?

15. Do you need help with preparing meals, transportation, shopping, taking your medicine, managing your finances, or other activities of daily living? If so, describe.

16. Do you worry about falling or have you had any falls?

17. Does your home have throw rugs, poor lighting or a slippery bathtub/shower?

18. Does your home LACK grab bars in bathrooms or handrails on stairs and steps?

Patient Name:______________________________

19. Does your home LACK functioning smoke alarms?

20. Do you have trouble hearing the television or radio when others do not?

21. Do you have to strain or struggle to hear/understand conversations?

22. Do you have a living will? If not, would you like to discuss this?

23. FAMILY HISTORY:

	Age if living	Age at death	Health problems or cause of death
Mother			
Father			
Brothers/Sisters			
Children			
Other			

*Please include cancer, diabetes, heart problems, high blood pressure, strokes, and other important illnesses.

24. PREVENTIVE MEDICINE:

Check if you've had	**VACCINATIONS**	Date of last one		Check if you've had	**TESTS**	Date of Last one
	Tetanus				Colonoscopy	
	Influenza (flu)				Bone density	
	Pneumonia				Mammogram	
	Hepatitis A				Pap smear	
	Hepatitis B				PSA	
	Shingles				Eye exam	
	Other (list)					