Entira FAMILY CLINICS
Where generations thrive®

ANNUAL WELLNESS VISIT QUESTIONNAIRE

NAME_____ **BIRTHDATE** _____

PRIMARY PROVIDER _____ **APPT DATE**_____

CURRENT PROVIDERS AND SUPPLIERS
(i.e. Provider – Cardiologist; Supplier – Pharmacy, Oxygen, DME)

Provider Name

_____ _____

_____ _____

_____ _____

_____ _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle your answer)

	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

If you marked a 2 or 3 on either of the above questions PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

CURRENT MEDICATIONS: **[ ] Reviewed and verified**

DRUG ALLERGIES/DRUG SENSITIVITIES: **[ ] Reviewed and verified**

PAST SURGERIES: **[ ] Reviewed and verified**

PAST HOSPITALIZATIONS: **[ ] Reviewed and verified**

FAMILY HISTORY: **[ ] Reviewed and verified**

Scan in Medicare Annual Wellness Folder as: MM/DD/YYYY Annual Wellness Visit Questionnaire

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "√" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself--or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	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	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
TOTAL:				

10 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	

Social and Safety Questionnaire

Do you use tobacco? If yes, How many years? How many per day?	YES	NO
Who do you live with?		
Married/ Single/ Divorced/ Widowed		
Are you exposed to second hand smoke?	YES	NO
What is your highest level of education?		
Do you use any recreational drugs?	YES	NO
What are your hobbies?		
Do you exercise?	YES	NO
Do you have any pets?	YES	NO
Are you sexually active?	YES	NO
If yes: with: Male Female Both		
Do you wear your seatbelt?	YES	NO
Do you feel safe at home?	YES	NO
Do you drink caffeine?	YES	NO
What is your religion?		
Do you have any guns in the home?	YES	NO
Do you have any financial concerns?	YES	NO
In general, how would you rate your overall **physical health?**	Excellent/ Good	Fair/ Poor
In the past 6 months, have you been bothered by leaking of urine?	YES	NO
In general, how would you rate your overall **mental** or **emotional health?**	Excellent/ Good	Fair/ Poor
Have you had any falls in the last year? If so: How many falls? Any Injuries?	YES	NO
Do you need help with preparing meals?	YES	NO
Do you need help with transportation?	YES	NO
Do you need help with shopping?	YES	NO
Do you need help with taking medicine?	YES	NO
Do you need help with managing finances?	YES	NO
Do you need help with other activities or daily living?	YES	NO
Do you live alone	YES	NO
Do you have any throw rugs in your home?	YES	NO
Do you have poor lighting in your home?	YES	NO
Do you have a slippery bathtub/shower?	YES	NO
Does your home have grab bars in the bathroom?	YES	NO
Does your home have handrails on stairs or steps?	YES	NO
Do you have working smoke alarms in your home?	YES	NO
Do you have trouble hearing the television or radio?	YES	NO
Do you strain or struggle to hear/understand conversations?	YES	NO
Do you have an Advance Directive? On file?	YES	NO

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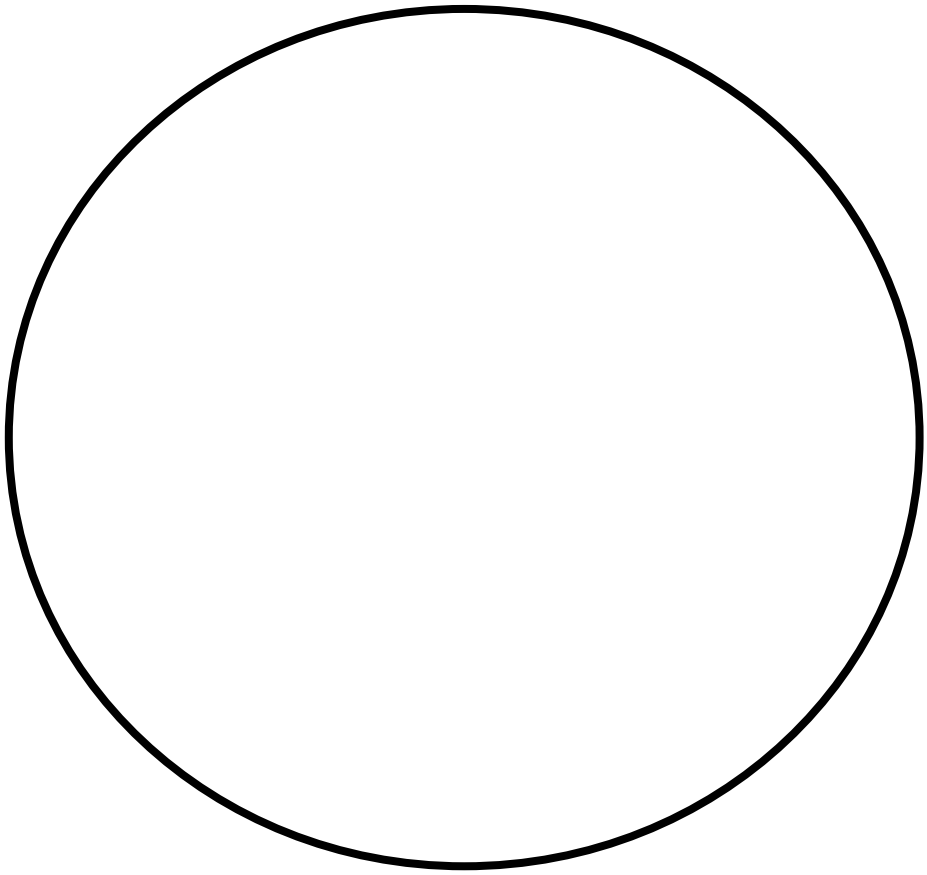

PERSONALIZED HEALTH PLAN

NAME:	DATE OF BIRTH:	DATE OF SERVICE:	
Preventive screen (frequency)	**Coverage**	**Previously tested (If yes, when?)**	**Scheduled for screenings**
Bone Mass Measurements (every 24 months)	Medicare patients at risk for developing Osteoporosis		
Cardiovascular Screening Blood Tests(every 5 yrs) – **Lipid panel** – **Cholesterol** – **Lipoprotein** – **Triglycerides**	All asymptomatic Medicare patients		
Colorectal Cancer Screening – **Flexible sigmoidoscopy** (4 years, or once every 10 years after a screening colonoscopy – **Screening colonoscopy** (every 24 months at high risk; every 10 years not at high risk) – **Fecal occult blood test** (annually) – **Barium enema** (every 24 months at high risk; every 4 years not at high risk) **– Cologuard** (every 3 yrs)	– Medicare patients age 50 and up – Screening colonoscopy: Those at high risk; no minimum age – No minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the patient is at high risk		
Diabetes Screening Tests (2 screening tests per year)	Medicare patients with certain risk factors for diabetes or diagnosed with pre-diabetes (patients previously diagnosed with diabetes aren't eligible for benefit)		
Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (Up to 10 hours of initial training within a continuous 12- month period; subsequent years up to 2 hours of follow-up training each year after initial year)	Medicare patients at risk for complications from diabetes, recently diagnosed with diabetes or previously diagnosed with diabetes (must certify DSMT need)		
Glaucoma Screening (annually for patients in one of the high risk groups)	Patients with diabetes mellitus, family history of glaucoma, African-Americans age 50 and over, or Hispanic-Americans age 65 and up		
Prostate Cancer Screening (annually) – **Digital rectal exam** – **Prostate specific antigen test**	All male patients 50 or older		
Screening Pap Tests and Pelvic Examination (annually if high-risk, or childbearing age with abnormal Pap test within past 3 years; every 24 months for all other women)	All female Medicare patients		
Screening Mammography (annually)	All female patients 40 or older		
Vaccines – **Prevnar / Pneumococcal** (at least 1 year apart) – **Seasonal Influenza** (once per flu season in the fall or winter) – **Hepatitis B** (scheduled dosages required)	All Medicare patients – May provide additional pneumococcal vaccinations based on risk and provided that at least 5 years have passed since previous dose – Hepatitis B, if medium/high risk		

Provider to give Personalized Health Plan to patient.