Primary Care Center
205N Belle Mead Road
East Setauket, NY 11733
(631) 444-4630
FAX (631) 444-4652

Dear _____,

Thank you for scheduling your Medicare Annual Wellness Visit. You may know already that Medicare has developed a new health care visit for its beneficiaries called an "Annual Wellness Visit." There is no co-pay for this visit, so it is free for you. It is important to know, however, that there may be fees associated with studies ordered during this visit. The goal of this visit is to provide time for you to focus on areas of your health that put you at risk for problems in the future. As part of the visit, you will be screened for fall risk, safety risk, worsening memory, depression and other medical concerns. This visit does not include a thorough physical exam or discussion of your chronic health problems. This is a wellness visit. Medical problems addressed and discussed at this visit will incur a separate charge.

In order to help the visit run smoothly, please **arrive 20 minutes prior to your scheduled appointment,** please **bring all your medicine bottles** and complete the enclosed forms and bring them with you to your visit. **If you arrive at the Primary Care Center without these forms, your visit will be rescheduled.** When you arrive at the Primary Care Center, please tell the staff that you are here for your Medicare Annual Wellness Visit. We look forward to seeing you in the office.

Sincerely,

Stony Brook Primary Care Physicians and Staff

Name: _____ MRN: _____ Date: _____

A Checklist for Your Medicare Wellness Annual Visit

Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible.

1. Are you:
   - ☐ Male
   - ☐ Female

2. What is your race? (check one or more than one)
   - ☐ White
   - ☐ Black/African American
   - ☐ Asian
   - ☐ Native Hawaiian/Other Pacific Islander
   - ☐ American Indian/Alaskan Native
   - ☐ Hispanic or Latino origin or descent
   - ☐ Other

3. How old are you?
   - ☐ 65-69
   - ☐ 70-74
   - ☐ 75-84
   - ☐ 85 or older

4. In general, compared to other people your age, would you say your health is:
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

5. How much difficulty, on average, do you have with the following physical activities:

	No difficulty	A little difficulty	Some difficulty	A lot of difficulty	Unable to do
Stooping, crouching or kneeling					
Lifting or carrying objects as heavy as 10 pounds					
Reaching or extending arms above shoulder level					
Writing or handling and grasping small objects					
Walking a quarter of a mile					
Heavy housework such as scrubbing floors or washing windows					

6. Because of your health or a physical condition, do you have any difficulty:
   A. Shopping for personal items (like toilet items or medicine)?
   - YES>> Do you get help with shopping? YES NO
   - NO
   - DON'T DO>> Is that because of your health? YES NO

   B. Managing money (like keeping track of expenses or paying bills)?
   - YES>> Do you get help with managing money? YES NO
   - NO
   - DON'T DO>> Is it because of your health? YES NO

   C. Walking across the room? USE OF CANE OR WALKER IS OKAY
   - YES>> Do you get help with walking? YES NO
   - NO
   - DON'T DO>> Is that because of your health? YES NO

   D. Doing light housework (like washing dishes, straightening up, or light cleaning)?
   - YES>> Do you get help with light housework? YES NO
   - NO
   - DON'T DO>> Is that because of your health? YES NO

   E. Bathing or showering?
   - YES>> Do you get help with bathing or showering? YES NO
   - NO
   - DON'T DO>> Is that because of your health? YES NO

7. Please check the correct answer:

	WITHOUT HELP (2)	WITH SOME HELP (1)	UNABLE (0)	N/A
Are you able to dress and undress yourself				
Are you able to feed yourself				
Are you able to walk				
If you cannot walk, can you get from one place to another (toilet, bed, wheelchair)				
Are you able to control your urination				
Are you able to control your bowel movements				
Are you able to take care of your appearance, i.e. grooming				
Can you shower or bathe				

8. Please circle the appropriate answer:

A. Can you go shopping for groceries or clothes (assuming you have access to transportation)

2 – without help (taking care of all shopping needs yourself);
1 – with some help (need someone to go with you on all shopping trips); or
0 – are you completely unable to do any shopping?

B. Can you do your housework:

2 – without help (can scrub floors, etc.);
1 – with some help (can do light housework, but need help with heavy work); or
0 – are you completely unable to do any housework?

C. Can you handle your own money:

2 – without help (write checks, pay bills, etc.);
1 – with some help (can manage day-to-day buying, but need help managing your checkbook and paying your bills); or
0 – are you completely unable to handle money?

D. Can you prepare your own meals:

2 – without help (plan and cook full meals yourself);
1 – with some help (can prepare some things, but unable to cook full meals yourself); or
0 – are you completely unable to prepare any meals?

E. Can you use the telephone:

2 – without help, including looking up numbers and dialing;
1 – with some help (can answer phone or dial operator in an emergency, but need a special phone or help in looking up numbers or dialing); or
0 – are you completely unable to use the telephone?

F. If you take medications, are you able to take your own medication:

2 – without help (correct doses, time intervals, etc.);
1 – with some help (reminding, preparation, etc.); or
0 – are you unable to take your own medication?

G. Can you get to places out of walking distance:

2 – without help (can travel alone on buses, taxis or drive own car);
1 – with some help (need someone to help you or go with you when traveling); or
0 – are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?

9. During the past 4 weeks, has your physical and emotional health limited your social activities with family, friends, neighbors or groups?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

10. Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things:

- 0 – Not at all
- 1 – Several days
- 2 – More than half the days
- 3 – Nearly every day

Feeling down, depressed or hopeless:

- 0 – Not at all
- 1 – Several days
- 2 – More than half the days
- 3 – Nearly every day

11. During the past 4 weeks, how much bodily pain have you generally had?

No Pain Severe Pain

0	1	2	3	4	5	6	7	8	9	10

12. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself?

- ☐ Yes, as much as I wanted
- ☐ Yes, quite a bit
- ☐ Yes, some
- ☐ Yes, a little
- ☐ No

13. In the past year, has anyone physically, verbally or financially hurt you?

☐ YES ☐ NO

14. DRIVER SAFETY:

Are you having difficulties driving your car?

- ☐ Yes, often
- ☐ Sometimes
- ☐ No

Any motor vehicle accidents in the past year?

- ☐ Yes
- ☐ No

Do you always fasten your seat belt when you are in a car?

- ☐ Yes, usually
- ☐ Yes, sometimes
- ☐ No

15. FALLS

Have you fallen in the past year?

☐ Yes ☐ No

If yes, how many? _____

Have you ever had a fall with injury?

☐ Yes ☐ No

If yes, type of injury _____

_____

Are you afraid of falling?

☐ Yes ☐ No

16. SMOKING

Are you a smoker?

- ☐ No
- ☐ Yes, and I might quit
- ☐ Yes, but I'm not ready to quit

17. EXERCISE

Do you exercise for about 30 minutes 5 or more days a week?

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ No, I usually do not exercise this much

If no, how much exercise do you do?

_____

18. MEDICATION

How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medications
- ☐ I always take them as prescribed
- ☐ Sometimes I take them as prescribed
- ☐ I seldom take them as prescribed

19. WEIGHT

Have you had recent weight gain?

☐ Yes ☐ No

If yes, how much gained? _____

Have you had recent weight loss?

☐ Yes ☐ No

If yes, how much lost? _____

Are you on a special diet? _____

_____

20. Please provide a complete list of the following items:

- List of the doctors and specialists that you see:

_____ _____

_____ _____

_____ _____

_____ _____

- List of your medications and supplements, including doses:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

- List of your medical problems and surgeries:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

- Tell us what medical problems your parents, siblings, and children have or have had in the past:

Parents:

Siblings:
Children:

21. **Advanced Directive:** Do you have an advanced directive or living will? ☐ Yes ☐ No ☐ I don't know

Health Care Proxy: Person you want to make health care decisions for you if you could not make them on your own:
Name: _____ Phone: _____
Relationship to you: _____

22. **Home Safety**

Yes	**No**	
☐	☐	Are emergency numbers kept by the phone and regularly updated?
☐	☐	Are all household members aware of the dangers of smoking, especially in bed?
☐	☐	If you own firearms, are they stored unloaded and securely locked?
☐	☐	Are working smoke alarm(s) and fire extinguisher(s) available for use?
☐	☐	Do all household members know how to use them?
☐	☐	Have throw rugs been removed or fastened down?
☐	☐	Are all electrical cords in working order, easily seen, and not run under rugs/carpets or wrapped around nails?
☐	☐	Do all stairways have a railing or banister?
☐	☐	Are doorways, halls, and stairs free of clutter?
☐	☐	Are sidewalks and all outdoor steps clear of tools, toys, and other articles

Comments _____

_____

23. **Hearing Screening:**

Item	(4)Yes	(2)Sometimes	(0) No
1. Does a hearing problem cause you to feel embarrassed when you meet new people?			
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?			
3. Do you have difficulty hearing when someone speaks in a whisper?			
4. Do you feel handicapped by a hearing problem?			
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?			
6. Does a hearing problem cause you to attend religious services less often than you would like?			
7. Does a hearing problem cause you to have arguments with family members?			
8. Does a hearing problem cause you difficulty when listening to TV or radio?			
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			

24. **Alcohol Use Screen:** *Please circle your answer to each question:*

1. How often did you have a drink containing alcohol in the past year?
   a. Never
   b. Monthly or less
   c. Two to four times a month
   d. Two to three times per week
   e. Four or more times a week
2. How many drinks did you have on a typical day when you were drinking in the past year?
   a. 1 or 2
   b. 3 or 4
   c. 5 or 6
   d. 7 to 9
   e. 10 or more
3. How often did you have five or more drinks on one occasion in the past year?
   a. Never
   b. Less than monthly

c. Monthly
d. Weekly
e. Daily or almost

25. **HIV Risk:**

How many sexual partners have you had in the last 10 years? _____

26. **Additional Screening Studies For MEN:**

Have you had the following study?	Yes	No	I Don't Know
1. A colonoscopy? If yes, when and where?			
2. An abdominal aortic aneurysm ultrasound? If yes, when and where?			

Additional Screening Studies for WOMEN:

Have you had the following study?	Yes	No	I Don't Know
1. A colonoscopy? If yes, when and where?			
2. A mammogram? If yes, when was your last one?			
3. A bone density test (DEXA)? If yes, when was your last one? _____			

27. **Immunizations:** Have you received an immunization (e.g. tetanus shot, flu shot, pneumonia shot) elsewhere in the past year? ☐ Yes ☐ No

If yes, please list those you have received outside Stony Brook:

_____

_____