Sweetwater Medical Associates

Annual Wellness Visit (AWV)

The goals of the AWV are health promotion, disease prevention and detection. This is not a routine annual physical. Medicare pays for one Initial AWV per beneficiary per lifetime after the first 12 months of the effective date of becoming active on Medicare Part B, or after the Initial Preventive Physical Exam (IPPE); and then a subsequent AWV annually there after.

Filling out this form before your visit will assist your provider with preventive recommendations.

General Information:

Member Name: ______________________________

D.O.B.: ____________________

Primary Care Physician: *(Circle one)* Dr. Alford Dr. Shaffer Dr. White

Current Medications:

Medication	Dose	Last Refill Date	Reason/Dx

Supplements/Vitamins	Dose	Duration/Frequency

Other/Illegal Drugs	Dose	Duration/Frequency

Opioid Risk Tool:

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals *(For Office Use Only)*		

Physical Activity/Nutrition:

Do you exercise on a regular basis? (*Circle*) Yes No

If yes, _________ times a week for _________ mins.

Types of exercise:	Walking	Weights	Floor exercises
(Circle)	Running	Swimming	Other _______________
	Aerobics	Zuma	Other _______________

Do you understand how regular exercise can benefit you? (*Circle*) Yes No

In a typical Week:

How many servingsof fruits and vegetables do you eat each day? _______ servings/day

How many servings of high fiber or whole grains do you eat daily? _______ servings/day

How many servings fo fried or high-fat foods do you eat daily? _______ servings/day

How many sugar-sweetened (not diet) beverages do you drink daily? ______ sugar sweetened drinks/day

Advance Directive Documentation/Education:

Do you have an advance directive? *(Circle)* Yes No

If yes, bring a copy of it or document the name of the Provider that has your Advance Directive:

____

Fall Risk Assessment:

How many times have you fallen in the last 12 months? (Circle) 1 2 3+

If you have fallen, did you sustain any injuries: (Circle) Yes No

Whay types of injuries did you have? ____

____

Were you hospitalized? (Circle) Yes No

Hearing Impairment:

Please **circle** YES, SOMETIMES, OR NO to each of the following items. Please do not skip a question. If you have a hearing aid, please answer the way you hear without the aid.

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

For Provider Use Only:

Total Score:_______

Subtotal E: ________

Subtotal S: ________

Activities of Daily Living:

Mark with a "x"

Activity	No Help Needed (2 *pts. Each)*	Need Some Help (1 *pt. each)*	Unable to Do At All *(0 pts. Each)*
1. Using the telephone			
2. Getting to places beyond walking			
3. Grocery shopping			
4. Preparing meals			
5. Doing housework or handyman			
6. Doing laundry			
7. Taking medications			
8. Managing money/bills			
Total Score: _______ = *(For Office Use Only)*	*(___x 2 =)___ +*	*(____x 1 =)____ +*	*0*

Home Safety:

Do you have good lighting inside and outside your home? *(Circle)* Yes No

Do you have handrails on stairs? *(Circle)* Yes No

Do you have handrails in bathtub/shower? *(Circle)* Yes No Not Needed

Current Providers and Suppliers:

Please list the doctors and providers who are involved in your care.

Name of the doctor/provider	Reason for care	Date last seen	Phone Number

Medical Vendors:

Name of Company	What is supplied	Phone Number

Demographic Data:

Are you living:	Alone	With Spouse/Family	Facility
Do you have a caretaker? Circle	Yes	No	
Is the caretaker present during the visit?	Yes	No	N/A
Language spoken in the home:	______________________		

Self-assessment of health status:

In the past 4 weeks, how much pain have you felt? *(Circle)*	A lot	Some None
If your blood pressure was checked within the past year what was it when it was last checked? *(Circle)*	at/below 120/80 120/80 to 139/89	140/90 or higher I'm not sure
If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked? *(Circle)*	below 200 200-239	240 or higher I'm not sure
If your glucose waas checked, what was your fasting blood glucose (blood sugar) level the last time it was checked? *(Circle)*	below 100 100-125	126 or higher I'm not sure
If you have diabetes, and if you have had your hemoglobin A1c level checked in the past year, what was it the last time you had it checked? (Circle)	6 or lower 7	8 or higher I'm not sure
In general, would you say your health is...? *(Circle)*	Excellent Very Good Good	Fair Poor
How would you describe the condition of your mouth and teeth? (including false teeth or dentures) *(Circle)*	Excellent Very Good Good	Fair Poor

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 figety 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	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). 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	________

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The AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization and the Generalitat Valenciana Conselleria De Benestar Social. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.who.org.