

Medicare Preventive Services

Welcome to Medicare Exam

What is the “Welcome to Medicare” exam?

The “Welcome to Medicare” exam helps you and your doctor develop a personalized plan to prevent disease, improve your health, and help you stay well.

It’s covered by Original Medicare (Part B) and Medicare Advantage Plans.

You can get the exam during the first 12 months you have Medicare.

After the first year you can get a yearly “Wellness” exam for free.

What should you expect during the exam?

During the exam your doctor will:

- Record and evaluate your medical and family history, current health conditions and prescriptions.
- Check your blood pressure, vision, weight, height, and calculate your body mass index (BMI).
- Make sure you’re up-to-date with preventive screenings and services, such as cancer screenings and shots.
- Order further tests, depending on your general health and medical history.

Following the exam, your doctor will give you a plan or checklist with screenings and preventive services that you need.

Annual Wellness Exam

What is the “Annual Wellness” exam?

The “Annual Wellness Exam” helps you and your doctor to develop or update a personalized prevention plan based on your current health and risk factors.

It’s covered once every 12 months.

What should you expect during the exam?

During the exam your doctor will:

- Review your medical and family history
- Make a list of current providers and prescriptions
- Check your height, weight, blood pressure and other routine measurements.
- Update your list of preventive services
- Develop a list of risk factors and treatment options for you

Important for you to know: Medicare does not provide free coverage for Routine or Complete physicals.

- Both exams may be performed by either a doctor of medicine or osteopathy or by a qualified non-physician practitioner- (physician assistant, nurse practitioner or clinical nurse specialist).
- The exams are preventive exams and are not a ‘routine physical checkup’ that some seniors may receive every year or two. The exams will not address on going medical conditions or medicine refill as part of the free coverage.

FOR MORE INFORMATION ON YOUR PREVENTIVE SERVICE BENEFITS VISIT:
WWW.MEDICARE.GOV Go to the ‘MANAGE YOUR HEALTH’ tab.

Medicare Primary Insurance Preventive Visit

Patient: _____ **Date of Birth:** _____

Reason for today's visit: (check one)

- Medicare Initial Preventive Physical Exam-“Welcome to Medicare Visit”
- Medicare Annual Wellness Visit

Please list all of your current medications and supplements, including calcium and vitamins:

Please list all of your current providers of health care other than the provider you are seeing today, listing any specialists and suppliers of medical equipment:

Have you seen an eye doctor in the last 12 months? No__ Yes__ Date:_____

Who is your eye care provider?_____

Was a glaucoma screen administered during your visit? No__ Yes__ Not known_____

If yes, what were the results? _____

Please indicate if you have had:

Seasonal Flu vaccine: No__ Yes__ Date:_____

Pneumococcal vaccine: No__ Yes__ Date:_____

Hepatitis B vaccine: No__ Yes__ Date:_____

Do you experience any of the following:

Difficulty hearing others? No__ Yes__

Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? No__ Yes__

Do you have rugs in your hallways at home? No__ Yes__

Do you have grab bars in your bathroom? No__ Yes__

Do you have handrails on stairs at home? No__ Yes__

Do you have poor lighting in your home? No__ Yes__

Would you like to discuss end of life planning today? No__ Yes__

Staff use

Height:_____ Weight_____ BP_____

Visual Acuity: L 20/____ R 20/____ Both_____ with W/O correction

PMH, FH, SH, MP, HM tabs updated? _____ Need updated HHx_____

College Park Family Care Center

BAI PATIENT SELF-EVALUATION

Patient's name:	Date:
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Instructions: Indicate how much you have been bothered by each symptom during the past week, including today, by circling the number in the column that most closely corresponds to how you've been feeling.

	NOT AT ALL	MILDLY It did not bother me much.	MODERATELY It was very unpleasant but I could stand it.	SEVERELY I could barely stand it.
<input type="checkbox"/> 1 Numbness or tingling	0	1	2	3
<input type="checkbox"/> 2 Feeling hot	0	1	2	3
<input type="checkbox"/> 3 Wobbliness in legs	0	1	2	3
<input type="checkbox"/> 4 Unable to relax	0	1	2	3
<input type="checkbox"/> 5 Fear of the worst happening	0	1	2	3
<input type="checkbox"/> 6 Dizzy or lightheaded	0	1	2	3
<input type="checkbox"/> 7 Heart pounding or racing	0	1	2	3
<input type="checkbox"/> 8 Unsteady	0	1	2	3
<input type="checkbox"/> 9 Terrified	0	1	2	3
<input type="checkbox"/> 10 Nervous	0	1	2	3
<input type="checkbox"/> 11 Feeling of choking	0	1	2	3
<input type="checkbox"/> 12 Hands trembling	0	1	2	3
<input type="checkbox"/> 13 Shaky	0	1	2	3
<input type="checkbox"/> 14 Fear of losing control	0	1	2	3
<input type="checkbox"/> 15 Difficulty breathing	0	1	2	3
<input type="checkbox"/> 16 Fear of dying	0	1	2	3
<input type="checkbox"/> 17 Scared	0	1	2	3
<input type="checkbox"/> 18 Indigestion or discomfort in abdomen	0	1	2	3
<input type="checkbox"/> 19 Faint	0	1	2	3
<input type="checkbox"/> 20 Face flushed	0	1	2	3
<input type="checkbox"/> 21 Sweating (not due to heat)	0	1	2	3

Column Sum				
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Total Score	
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College Park Family Care Center

BDI-PC PATIENT SELF-EVALUATION

Patient's name:	Date:
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Instructions: This questionnaire consists of seven groups of statements. Read each group of statements carefully, then pick out the **one statement** in each group that best describes the way you have been feeling during the **past 2 weeks, including today**. Circle the number beside the statement you have picked. If several statements in one group seem to apply equally well, choose the statement with the highest number beside it.

1	Sadness	I do not feel sad.....	0
		I feel sad much of the time.....	1
		I am sad all the time.....	2
		I am so sad or unhappy that I can't stand it.....	3
2	Pessimism	I am not discouraged about the future.....	0
		I feel more discouraged about my future than I used to be.....	1
		I do not expect things to work out for me.....	2
		I feel my future is hopeless and will only get worse.....	3
3	Past Failure	I do not feel like a failure.....	0
		I have failed more than I should have.....	1
		As I look back, I see a lot of failures.....	2
		I feel I am a total failure as a person.....	3
4	Self-Dislike	I feel the same about myself as ever.....	0
		I have lost confidence in myself.....	1
		I am disappointed in myself.....	2
		I dislike myself.....	3
5	Self-Criticalness	I don't criticize or blame myself more than usual.....	0
		I am more critical of myself than I used to be.....	1
		I criticize myself for all of my faults.....	2
		I blame myself for everything bad that happens.....	3
6	Suicidal Thoughts or Wishes	I don't have any thoughts of killing myself.....	0
		I have thoughts of killing myself, but I would not carry them out.....	1
		I would like to kill myself.....	2
		I would kill myself if I had the chance.....	3
7	Loss of Interest	I have not lost interest in other people or activities.....	0
		I am less interested in other people or things than before.....	1
		I have lost most of my interest in other people or things.....	2
		It's hard to get interested in anything.....	3

Total Score: