Drs. Shanahan & Ferguson
Patrick J. Shanahan, M.D.
Andrew S. Ferguson, M.D.

Get Ready for your Annual Wellness Visit

Dear Patient:

Thank you for scheduling your Medicare annual wellness visit. As a reminder, the Medicare wellness assessment focuses on health promotion and prevention. At this wellness visit, we will identify your health risks and try to reduce them. During this visit, we will:

>Review your health history

>Review any screenings and tests you may need

>Check for immunizations

>Check your blood pressure and weight

Please complete the Medicare Annual Wellness Assessment paperwork in preparation of your visit. Email the packet back to us or bring it with you to your appointment.

Sincerely,

Drs Shanahan and Ferguson PC

AWV 4/2021

Medicare Wellness Visit

Patient Name_____**Date of Birth**:_____

Patient Care Team

Please list all physicians and consultants engaged in your care in the last two years:
Cardiology: _____
Dermatology: _____
Gastroenterology: _____
Gynecology: _____
Hematology: _____
Nephrology: _____
Neurology: _____
Oncology: _____
Ophthalmology:
Orthopedics: _____
Pulmonary: _____
Rheumatology:
Surgery: _____
Urology:
Other Providers: _____

Please list all Durable Medical Equipment Companies who currently supply your medical supply needs:
02 Supplier: _____
What liter level is your 02 tank normally set? _____
Walkers, rollators, and/or wheelchairs supplier: _____
Nebulizer, CPAP, other pulmonary device supplier: _____
How often do you use a nebulizer? _____

Please list all Diabetic Supply Companies who currently supply your diabetic equipment:
_____How often do you test? _____

Demographics:

How old are you? _____
What is your ethnicity?
☐ American Indian
☐ Asian
☐ Black/African ☐ Hispanic/Latino
☐ Non-Hispanic/White
Marital Status:
☐ Married
☐ Divorced
☐ Widowed
☐ Never married
☐ Part of an unmarried couple
Employment Status:
☐Employed
☐ Homemaker
☐ Out of work
☐ Retired
☐ Self-employed

☐ Unable to work
How many children do you have? Living _____Deceased _____

Risk Assessment

How often do you exercise?
☐ Never
☐ Daily
☐ Often
☐ Rarely
Please list what type of exercise you prefer (walking, gardening, golfing, swimming, etc.) _____
How vigorously do you exercise?
☐ Not at all
☐ Minimally
☐ Moderately
☐ Very vigorously
How often do you use seatbelts?
☐ Never
☐ Sometimes ☐ Most of the time ☐ Always

Do you have any problems with sex?
☐ Yes
☐ No

General Health/Pain Assessment

In the past month, how often did you experience pain?
☐ Never
☐ Daily
☐ Frequently
☐ Most Days
☐ Rarely

How much has pain affected your ability to walk?
☐ Not at all
☐ A little
☐ Moderate Degree
☐ Extreme degree

Has your pain affected your relationship with people?
☐ Not at all
☐ A little
☐ Moderate Degree
☐ Extreme degree

On a scale of 1-10, how would you rate your average daily pain? _____

How would you describe the ease with which you can prepare you own food?
☐ Very easy
☐Easy
☐A little difficult

☐Very difficult
☐I can't prepare my own food

How would you describe the ease with which you can bathe or clean yourself?
☐ Very easy
☐Easy
☐A little difficult
☐Very difficult
☐I can't bathe or clean myself

How would you describe the ease with which you can dress yourself?
☐ Very easy
☐Easy
☐A little difficult
☐Somewhat difficult
☐Very difficult
☐I can't dress myself at all

How hard is it too use the toilet by yourself?
☐ Very hard
☐ Somewhat hard
☐A little hard
☐Not hard at all

How would you describe the ease with which you can do your own shopping?
☐ Very easy
☐Easy
☐A little difficult
☐Somewhat difficult
☐Very difficult
☐ I can't get do my own shopping

How would you describe the ease with which you can get around the house?
☐ Very easy
☐Easy
☐A little difficult
☐Somewhat difficult
☐Very difficult
☐ I can't get around the house without assistance

How would you describe your ability to pay your bills?
☐Very good
☐Good
☐Adequate
☐ Poor
☐Very poor

How would you describe your ability to do routine housework?
☐Very good
☐Good
☐Adequate
☐ Poo
☐Very poor

Home Safety / Assistance

Do you feel like you are safe in your current home?
☐ Yes
☐ No

How many times have you fallen in your home?
☐Never
☐ Once
☐A few times
☐ Many times
☐ All the time

How much would you need to change your living circumstances to feel safe?
☐ Not at all
☐ A little
☐ Quite a bit
☐ A significant amount

Do you feel that living somewhere else would be good for you?
☐ Yes
☐No

How much help do you feel you need at home?
☐ None at all
☐ A little
☐Quite a bit
☐A significant amount

Drs. Shanahan and Ferguson, P.C.

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NAME: _____ DATE: _____

Patient Health Questionnaire- PHQ9

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

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead or of hurting yourself in some way				

Patient Health Questionnaire- SBIRT (2018 Edition)

Did you have a drink containing alcohol in the past year?
☐Yes ☐ No

If Yes, How often did you have a drink containing alcohol in the past year?
☐Never
☐Monthly or less
☐2-4 times a month
☐2-3 times a week
☐4 or more times a week

If Yes, How many drinks did you have on a typical day when you were drinking in the past year?
☐1-2 drinks
☐3-4 drinks
☐5-6 drinks
☐7-9 drinks
☐10 or more drinks

If Yes, How often did you have 6 or more drinks on one occasion in the past year?
☐Never
☐Less than monthly
☐Monthly
☐Weekly
☐Daily or almost daily

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?
☐ 0 times ☐1 or more times ☐ If, one or more times, how many times this year _____

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Patient Medical History - Please complete to update your medical record

Name: _____ Date of Birth: ___/___/ ____

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
Hypertension		Kidney - specify	
High Cholesterol		Gallstones	
Cancer – Location:		Hepatitis	
COPD, Emphysema or Asthma		Blood Clots	
Diabetes		TB Exposure	
GERD / Reflux		Thyroid Condition - Specify	
Depression or Anxiety			
Heart Problems -		Other(s):	

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	*Living or Deceased*	*Current age or age at death*	*Cause of Death*	*Health Problems*
Father:				
Mother:				
Brother(s):				
Sister(s):				

Tobacco: Are you a current smoker? Yes No If you smoke, how many packs per day?

Are you a former smoker? Yes No How many months/ years since you quit?

Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		*Month/Yr*
Shingles Vaccine		Mammogram	
Pneumonia Vaccine		Colonoscopy	
Tetanus Vaccine			
Hepatitis B Vaccine		If you are a diabetic, when was your last Eye Exam?	