

Drs. Shanahan & Ferguson

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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:

O2 Supplier: _____

What liter level is your O2 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
- Poor
- 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 _____

Patient Medical History - Please complete to update your medical record

Name: _____

Date of Birth: ___/___/___

| ◆ Past Medical History ◆ | | | |
|---------------------------------|-------------------|-----------------------------|-------------------|
| <i>Condition / Disease</i> | <i>Year Began</i> | <i>Condition / Disease</i> | <i>Year Began</i> |
| 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 ◆ | | | |
|--|-------------------|---|-------------------|
| <i>Operation / Hospitalization / Injury</i> | <i>Month / Yr</i> | <i>Operation / Hospitalization / Injury</i> | <i>Month / Yr</i> |
| | | | |
| | | | |
| | | | |

| ◆ Family Health History ◆ | | | | |
|--|---------------------------|------------------------------------|-----------------------|------------------------|
| <i>Please list below the health history of your blood (genetic) first degree relatives</i> | | | | |
| <i>Relative</i> | <i>Living or Deceased</i> | <i>Current age or age at death</i> | <i>Cause of Death</i> | <i>Health Problems</i> |
| 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 ◆ | | | |
|--|-----------------|---|-----------------|
| <i>Please list below the most recent dates of your vaccines and health screening tests</i> | | | |
| | <i>Month/Yr</i> | | <i>Month/Yr</i> |
| Shingles Vaccine | | Mammogram | |
| Pneumonia Vaccine | | Colonoscopy | |
| Tetanus Vaccine | | | |
| Hepatitis B Vaccine | | If you are a diabetic, when was your last Eye Exam? | |

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NAME: _____ DATE: _____

Patient Health Questionnaire- PRAPARE Smart Form

Money and Resources

What is your current housing situation?

- I have housing
- I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street or a park)
- I choose not to answer this question

Are you worried about losing your housing?

- Yes
- No
- I choose not to answer this question

What is the highest level of school that you have finished?

- Less than a high school degree
- High school diploma or GED
- More than high school
- I choose not to answer this question

What is your current work situation?

- Unemployed and seeking work
- Part time or temporary work
- Full time work
- Otherwise, unemployed but not seeking work (student, retired, disabled, unpaid primary care giver)
- I choose not to answer this question

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply

- Food
- Clothing
- Utilities
- Child Care
- Medicine or any health care (medical, dental, mental health or vision)
- Phone
- Other (please write in)
- I do not have problems meeting my needs
- I choose not to answer this question

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- Yes, it has kept me from medical appointments or from getting my medications
- Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living
- No
- I choose not to answer this question

Social and Emotional Health

How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

- Less than once a week

- 1 or 2 times a week
- 3-5 times a week
- More than 5 times a week
- I choose not to answer this question

How stressed are you? Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much
- I choose not to answer this question

Additional Questions

In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

- Yes
- No
- I choose not to answer this question

Are you a refugee?

- Yes
- No
- I choose not to answer this question

What country are you from?

- United States
- Country other than the United States (please write in)
- I choose not to answer this question

Do you feel physically and emotionally safe where you currently live?

- Yes
- No
- Unsure
- I choose not to answer this question

In the past year, have you been afraid of your partner or ex-partner?

- Yes
- No
- Unsure
- I have not had a partner in the last year
- I choose not to answer this question