Martha Gray, MD
Mark Oberdoerster, MD
Peter R. Paul, MD
Sara Hashemian, MD
Eric J. Straka, MD
Pamela Shore, MD
Blanka Girard, MD
Lisa Cogswell, MSN, ANP-BC

Partners In Internal Medicine

www.piim.org

2200 Green Road, Suite B
Ann Arbor, MI 48105
734-994-PIIM (7446)
734-623-8591 (Fax)

255 N. Lilley Road
Canton, MI 48187
734-981-3300
734-981-0653 (Fax)

Your Annual Medicare Wellness Visit

Preventive medicine, that is medicine and services that help you from being sick or help you manage your current conditions so they don't get worse, is one of the most important things you can do add longevity to your life. Your wellness visit is an opportunity for you and your doctor to discuss your general health during a time when you are not in for a sick or chronic care visit and therefore not focused on how you are feeling at the moment.

What to expect

You will be asked to fill out a **questionnaire** to help your doctor asses your current state of health. The doctor will review your answers to determine what your health risks are. This will become part of your Personalized Prevention Plan.

Your **height** and **weight** will be measured and your **BMI** (Body Mass Index) will be calculated. Your **blood pressure** will also be taken. This gives the doctor a quick picture of your current health and possible future risks.

Your **family, medical, and social history** will be updated to determine if you are at greater than average risk for certain diseases.

Your **medications** will be reviewed to be sure that there are no interactions with each other and that you are not taking any that you no longer need.

The list of **doctors** you are currently seeing will be reviewed, knowing who you are seeing and for what health issues allows us to better coordinate your care and contact the right doctor if needed.

You will leave with a personalized list of **recommended preventative services** giving the date you last had the service done and when you are due to have it repeated. You will also be given a list of your **health risks** and what your doctor wants you to do to prevent, manage, or reduce future health concerns.

After your visit, plan to have an open and honest discussion with your family. You should share with them your current health status, current risks, and additional screenings that are recommended. This is an opportunity to discuss what you want done in case of an emergency. Knowing what you would like done, or not done, when it comes to important health decisions is good for your family, your doctor, and you.

NOTE: This visit is not intended to be a physical examination or a visit to discuss chronic problems or acute symptoms you may be having. Please schedule an appointment for another time for these purposes.

Partners in Internal Medicine
Wellness Exam Questionnaire

Patient Name: Date of birth:

Today's Date:

Instructions: Please **circle** your answers.

Are you able to hear normal conversational voice?	Yes	No
Do you have and use hearing aids?	Yes	No
Do you have difficulty driving, watching TV, or reading because of poor eyesight?	Yes	No
Have you unintentionally lost weight in the last 6 months?	Yes	No
Do you have difficulty eating because of missing teeth or ill fitting dentures?	Yes	No
Have you ever lost urine or gotten wet?	Yes	No
Do you have trouble controlling your bowels?	Yes	No
Do you feel secure walking without help?	Yes	No
Do you use a cane, walker, or wheelchair?	Yes	No
How many falls have you had in the last year? Number____	Yes	No
Do you often feel sad or depressed?	Yes	No

Activities of Daily Living:

Are you (I) Independent requiring no help, (A) Need some help or assistance, (D) Cannot do at all, with the following tasks:

Walking	I A D	Using the telephone	I A D
Dressing	I A D	Shopping	I A D
Bathing	I A D	Preparing meals	I A D
Eating	I A D	House Work/Laundry	I A D
Toileting	I A D	Managing Finances	I A D
Driving	I A D	Taking Medications	I A D

What is your favorite leisure activity?_____

Do you find yourself avoiding this activity because it's difficult? Yes No

Do you live with anyone? Yes
No

If yes, who? Spouse Child Relative Friend Other

Who would make health care decisions for you if you are not able?

_____

List all Medications, prescription and over the counter, that you are taking.

_____ _____

_____ _____

_____ _____

_____ _____

What is your system for organizing and taking your medications?

Pillbox Family Help List or Chart None

List any other doctors you have seen in the last 12 months and the reason you are seeing them.

Doctor	Condition/Reason
_____	_____
_____	_____
_____	_____

Please draw the face of a clock with all the numbers and the handset to indicate 10 minutes after 11 o'clock.

For the nurse or doctor to fill in.

Recall #_____

Reviewing Physician:_____Date: _____

Name: **Date:**

Blood Pressure: **Height:** **Weight:** **BMI:**

Test/Screening/Service	Coverage Criteria	Date last done	Next Date due
Abdominal Aortic Aneurysm Screening	One time screening if you have one of the following: Family history of AAA Men age 65-75 that have smoked a hundred cigarettes in their lifetime		
Bone Density	Once every 24 months for those who are at risk for osteoporosis		
Cholesterol Screening	Every 5 years		
Fecal Occult Blood Test	Once every 12 months		
Colonoscopy	Once every 10 years for screening, once every 24 months if you are high risk		
Flu Shot	Once a year in the fall or winter		
Glaucoma Test	Once every 12 months if you: Have diabetes Have a family history of glaucoma Are African-American or Hispanic age 50 or older		
Hepatitis B Shot	A series of three shots if you meet the following criteria: End Stage Renal Disease Hemophilia Any condition that increases your risk for infection		
Mammogram (Screening)	Once every 12 months		
Pap Test and Pelvic Exam	Once every 24 months for screening, once every 12 months if you are high risk		
Pneumonia Shot	Most people only need this once in their lifetime		
Prostate Cancer Screening	A digital rectal exam and PSA blood test once every 12 months		
Smoking Cessation Counseling	Up to 8 face-to-face visits per 12 month period		
Diabetes Screening	Once every 6 months if you have one of the following risk factors: High blood pressure High cholesterol Obesity History of elevated blood sugar		
Diabetes Education	For people with diabetes		

Name:

Your Risk Factors	**Recommended follow-up:**
Falls/Fracture risk	Exercise(TaiChi, water aerobics) Physical Therapy for muscle strengthening, Life Line
Depression	Medication, counseling, psychiatrist
High Blood Pressure	Medication, monitor, diet
Tobacco abuse	Smoking cessation program
Overweight	Diet (Weight Watchers), exercise
Poor nutrition	Nutritional supplements (Ensure), Nutritionist, Dentist
Diminished hearing	Audiology
Poor vision	Ophthalmology

Follow with specialist:

Other Recommendations:

I understand the above recommendations: _____

Date: