Weston Family Medicine, LLC
Medicare Annual Wellness Forms

First Name________________________________ Last Name____________________________________

Date of Birth _______________ Today's Date _______________ Gender: Female Male Non-Binary

Permanent Street Address :____

City: __________________________ State: _______________________ Zip: ___________________________

Email Address: ____

Home Phone Number ___________________________ Cell Phone Number ____________________________

May we leave medical information on the voicemail of the above numbers? Yes No

How do you wish us to contact you? Cell # Home # Patient Portal

Marital Status (Circle One) Single Married Divorced Separated Widowed Other

Spouse's Name (If Applicable) ___________________________ Spouse's Phone #______________________

Emergency Contact Name _____________________________________ Relationship ____________________

Phone Number ______________________________ Alternative Number _____________________________

Can we speak to the above person regarding your personal, medical information? Yes No

What is the Medicare Annual Wellness Visit?

— This visit is for talking with your healthcare team about your medical history, your risk for certain diseases, the current state of your health and your plan for staying well.

— We will measure your height, weight and blood pressure.

— We might refer you for screenings or services outside of the appointment.

How is the Annual Wellness Visit different from other visits?

— This is not the same as a yearly physical exam.

— We will not listen to your heart and lungs or check other parts of your body.

— You probably will not get screenings or blood tests during this visit.

— We would want to schedule another appointment if you are not feeling well or are concerned about a medical problem.

Who pays for it?

— Medicare will pay for the Annual Wellness Visit so you will have no out of pocket expense.

— If you receive additional tests or services during the same visit that aren't covered under these preventive benefits, you may have a co-pay and the Part B deductible may apply.

Patient Checklist and Things to Bring to Your Visit:

______ Complete all of the forms and questionnaires provided in this packet and bring them to your visit.

______ Provide a list of other physicians or health care providers who are currently treating you.

______ Provide a list of medical equipment suppliers/companies (ex. oxygen supplier).

______Provide the names and locations of the pharmacies you use (including mail order).

______ Bring a bag with all of your current medications including over-the-counter drugs, vitamins and herbals.

Patient Name: ____

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Healthcare Team: Please list members of your current care team (i.e. physicians, medical clinics, visiting nurses, therapies, medical equipment supplier)

Eye Care Provider: ________________________________ Date of Last Exam: ______/______/______

Dental Provider: __________________________________ Date of Last Exam: ______/______/______

Other: ____

Other: ____

Other: ____

Allergies: ☐ No Known Allergies

Drug Name	Reaction You Had

List your prescribed drugs and over-the-counter drugs, such as vitamins: ☐ Not talking any Medications

Drug Name	Strength/ Mg Amount	Frequency	Reason

Continue medication list on back page if needed

Surgeries/Hospitalizations:

Year	Reason	Hospital

Review of Systems: (Check yes if you are currently suffering from the following)

Consitutional		**Cardiovascular**		**Psychiatric**	
Tired or Fatigue	☐ No ☐ Yes	Chest Pain	☐ No ☐ Yes	Anxiety	☐ No ☐ Yes
Weight Gain	☐ No ☐ Yes	Leg Swelling	☐ No ☐ Yes	Depression	☐ No ☐ Yes
Weight Loss	☐ No ☐ Yes	Palpitations	☐ No ☐ Yes	Insomnia	☐ No ☐ Yes

Respiratory		**Musculoskeletal**		**Metabolic/Endocrine**	
Chronic Cough	☐ No ☐ Yes	Joint Pain/Swelling	☐ No ☐ Yes	Cold Intolerance	☐ No ☐ Yes
Cough	☐ No ☐ Yes	Muscle Weakness	☐ No ☐ Yes	Heat Intolerance	☐ No ☐ Yes
Shortness of Breath	☐ No ☐ Yes			Increased Thirst	☐ No ☐ Yes
Wheezing	☐ No ☐ Yes			Increased Appetite	☐ No ☐ Yes

Reproductive (female)		**Reproductive (male)**		**Integumentary**	
Abnormal Pap	☐ No ☐ Yes	Erectile Dysfunction	☐ No ☐ Yes	Hives/Rash	☐ No ☐ Yes

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Reproductive (female)		Reproductive (male)		Integumentary	
Hot Flashes	☐ No ☐ Yes	Penile Discharge	☐ No ☐ Yes	Mole Changes	☐ No ☐ Yes
Vaginal Discharge	☐ No ☐ Yes	Sexual Dysfunction	☐ No ☐ Yes	Skin Lesions	☐ No ☐ Yes

HEENT		Hematologic		Genitourinary	
Hearing Loss	☐ No ☐ Yes	Easy Bleeding	☐ No ☐ Yes	Painful Urination	☐ No ☐ Yes
Nasal Drainage	☐ No ☐ Yes	Easy Bruising	☐ No ☐ Yes	Urinary Incontinence	☐ No ☐ Yes
Sinus Pressure	☐ No ☐ Yes			Blood In Urine	☐ No ☐ Yes
Trouble Swallowing	☐ No ☐ Yes			Urinary Frequency	☐ No ☐ Yes
Visual Changes	☐ No ☐ Yes			Urinary Retention	☐ No ☐ Yes

Gastrointestinal		Neurological	
Abdominal Pain	☐ No ☐ Yes	Dizziness	☐ No ☐ Yes
Blood In Stools	☐ No ☐ Yes	Numbness	☐ No ☐ Yes
Change in Stools	☐ No ☐ Yes	Weakness	☐ No ☐ Yes
Constipation	☐ No ☐ Yes	Headache	☐ No ☐ Yes
Diarrhea	☐ No ☐ Yes	Memory Loss	☐ No ☐ Yes
Heartburn	☐ No ☐ Yes	Tremors	☐ No ☐ Yes
Nausea	☐ No ☐ Yes	Loss of Balance	☐ No ☐ Yes

Screening Tests for Men and Women:

Test	Date	Results
Colonoscopy		
Bone Density		
Rectal Exam		
Complete Blood Tests		
Test for Blood In Stool		
Pelvic and Pap test (Women Only)		
Mammography		
Chest X-Ray		
PSA (Men Only)		
Eye Exam		

Personal Medical History:		
☐ Acid Reflux	☐ COPD	☐ Iron Deficiency
☐ Allergies	☐ Elevated Cholesterol	☐ Kidney Disease
☐ Anemia	☐ GI Disorder	☐ Lactose Intolerance
☐ Arthritis	☐ Gout	☐ Post/Menopausal
☐ Asthma	☐ Headache	☐ Osteoporosis
☐ Breast Feeding	☐ Heart Disease	☐ Pregnant Currently
☐ Bowel Irregularity	☐ Heart Murmur	☐ Prostate Disease
☐ Bronchitis	☐ Heart Palpitations	☐ Sexually Transmitted Infections
☐ Cancer	☐ Hepatitis	☐ Sickle Cell Disease
☐ Chronic Liver Disease	☐ High Blood Pressure	☐ Stroke/TIA
☐ Clotting Disorder	☐ HIV Infection	☐ Thyroid Disorder

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Family Health History:		☐ Adopted/Unknown	
Relative	**Alive or Deceased**	**Age**	**Significant Heath Problems/Cause of Death**
Father			
Mother			
Sibling ☐ M ☐ F			
Sibling ☐ M ☐ F			
Sibling ☐ M ☐ F			

Social History:	
Exercise	☐ No Exercise ☐ Mild Exercise (i.e. climb stairs, walk 3 blocks) ☐Occasional Vigorous Exercise (i.e. less than 3x/week for 30 min or less) ☐Regular Vigorous Exercise (i.e. 4x/week or more for 30 min or more)
Caffeine	☐None ☐Coffee ☐Tea ☐Cola # of Cups/Cans per day? ___________
Alcohol	Do You Drink alcohol? ☐Yes ☐No If yes, what types? ________________________________ How Many Drinks per Day? ___________ How Many Drinks per Week? _____________
Tobacco	Do You Use Tobacco? ☐Yes ☐No ☐Previous Smoker Year Started________ Year Quit________ ☐Cigarettes – _____ Pks./day ☐Chew-_____x/day ☐Pipe-_____x/day ☐Cigars-_____/day
Falls	Have You Fallen in the Past Year? ☐Yes ☐No If yes, did that fall result in injury? ☐Yes ☐No

Advanced Directives

Have you prepared a living will or advanced directives? ☐Yes ☐No
If so, is it on file with Weston Family Medicine? ☐Yes ☐No
Do you have Power of Attorney? ☐Yes ☐No
Power of Attorney (if not you) ___________________________ Relationship _________________________

Patient Health Questionnaire (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle the # to indicate your answer)	**Not At All**	**Several Days**	**More Than Half The Days**	**Nearly Every Day**
1. Little interest or please 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 fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
9. Thought that you would be better off dead or hurting yourself in some way	**0**	**1**	**2**	**3**
* **Scoring to be completed by office staff*** **Add Columns Total:**		________ + ________ + _______ = ________________________		

Patient Name: ____

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10. If you check off ANY problems, how difficult have the 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**

Health Assessment Questionnaire (HAQ-DD)				
Over the last 2 weeks how much difficulty have you had with the following activities?	**No Difficulty**	**Some Difficulty**	**Much Difficulty**	**Unable To Do**
Dress Yourself, including tying shoelaces and doing buttons	0	1	2	3
Shampoo your hair	0	1	2	3
Stand up from a straight chair	0	1	2	3
Get in and out of bed	0	1	2	3
Cut your meat	0	1	2	3
Lift a full cup or glass to your mouth	0	1	2	3
Open a milk cartoon	0	1	2	3
Walk outdoors on flat ground	0	1	2	3
Climb up five steps	0	1	2	3
Wash and dry your body	0	1	2	3
Take a tub bath	0	1	2	3
Get on and off the toliet	0	1	2	3
Reach and get down a 5lb object from just above your head	0	1	2	3
Bend down to pick up clothing from floor	0	1	2	3
Open car doors	0	1	2	3
Open jars which have been previously opened	0	1	2	3
Turn faucets on and off	0	1	2	3
Run errands and shop	0	1	2	3
Get in and out of a car	0	1	2	3
Do chores such as vacuuming or yard work	0	1	2	3

Please check any AIDS or DEVICES that you usually use:

☐Cane
☐ Walker
☐Crutches
☐ Wheelchair
☐Hearing Aid
☐Oxygen Tank

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Weston Family Medicine Policies

Cancellation Policy

At Weston Family Medicine your scheduled appointment time is reserved for you. There will be a $25.00 charge if you do not cancel or reschedule your scheduled appointment with a minimum of 24 hours in advance. If you miss your appointment, it is your responsibility to reschedule that appointment. ___________ (initial)

Financial Policy

It is your responsibility to be aware of your health insurance coverage, including but not limited to, the healthcare provider's participation in your particular plan and that you are financially responsible for any balance *not covered* by your health carrier. ___________ (initial)

Should your account default to collections, you will assume all costs pertaining to, but not limited to, court costs, interests, and legal fees. _____________ (initial)

Weston Family Medicine, LLC will release any medical information that might be necessary for your medical care or in processing your medical claims, with your permission. _____________ (initial)

Follow Up Policy

Your healthcare provider may request an office visit to discuss abnormal results. Otherwise a message from the healthcare provider will be relayed by the medical office staff. If you have ANY questions, regarding that message, an office visit with the healthcare provider is recommended. ___________ (initial)

During an office visit your medications are prescribed in an amount equal to the amount you will need until your next office visit. Your healthcare providers ask that you bring all of your medications, or an updated list of medications and dosages, to your appointments as it is crucial to proper medical treatment. ___________ (initial)

If after an appointment, your symptoms worsen or don't improve, it's your responsibility to make an appointment to return to the office or go to Urgent Care. Failure to follow instructions can result in injury or death. __________ (initial)

Referral Policy

You must give 5 days business notice for a referral to be approved and issued appropriately. Your healthcare provider must examine you and determine that a referral is necessary. ___________ (initial)

Medication Refill Policy

You must give 5 days business notice for a medication refill to be approved and processed appropriately. Your healthcare provider may need to examine you before issuing a refill. If this is necessary a refill will not be issued without a follow up visit. ___________ (initial)

Contact Policy

Your tests results will be relayed to you as soon as possible. Weston Family Medicine will make only 2 attempts to reach you, either by phone call and/or secured message via patient portal, with important, normal test results. Weston Family Medicine will make only 2 attempts to reach you by either a phone call and/or a secured message via the patient portal and 1 attempt by letter with abnormal test results. It's your responsibility to update all of your contact information for better communication with the office. ___________ (initial)

With your permission Weston Family Medicine will contact you through our HIPAA compliant patient portal. We may send messages to you regarding lab results, referrals, prescription refills, and/or diagnostic results. ___________ (initial)

By signing my initials and a smiley face, I acknowledge that I have read and agree to the above. ___________ (initial)

____   ______/_________/________

Patient Signature (Parent or Guardian)   **Date**

Patient Name: ____

Date of Birth: ________________________

Appointment Cancellation and No Show Policy

Thank you for trusting your medical care to Weston Family Medicine. When you schedule an appointment with Weston Family medicine we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible and no later than **24 hours** prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation and No Show Policy below:

- Effective February 1st, 2020 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours** notice will be considered a No Show and charged a **$25.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment without 24 hours notice a **second** time will be charged **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule without 24 hour notice should occur the patient may be **grounds for dismissal** from Weston Family Medicine,LLC.
- Any new patient who fails to show fo their initial visit will not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patients next office visit**, if not paid prior.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receipt reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, Mallory, who may be able to waive the No Show fee.

I have read and understand the Appointment Cancellation and No Show Policy and agree to its terms.

____

Patient/Guardian Signature

Patient Name: ____

Date of Birth: ______________________