Dear Valued Medicare Patient,

Thank you for scheduling your Annual Wellness Visit with us! As an eligible Medicare Part B member, Ogden Clinic is pleased to provide this important service to you. During your visit, we will review the medical and social histories related to your health. We will also provide education and counseling about preventive services, including certain screenings, immunizations, and referrals for other care.

Your health assessment will also include:

- Height, weight, and blood pressure measurements
- A calculation of your body mass index
- A review of your potential risk for depression and your level of safety
- An offer to discuss the value of creating advanced directives which tells your physician and other caregivers what you want, if you need care when you are unable to speak for yourself.
- A written plan letting you know which screenings, immunizations, and other preventive services you may need.

The Annual Wellness Visit is covered every 12 months for Medicare Part B eligible participants. While the wellness visit is completely covered by your insurance, you will likely be charged a copay if medications are renewed or you have additional medical concerns, testing or services performed during the visit; coinsurance and the Part B deductible may apply. Each year we will gather this information above to ensure our charts and documentation are properly updated.

In preparation for your visit, please complete the attached form. If you have questions regarding your Annual Wellness Visit, please feel free to contact us at (801) 475-3000. We look forward to seeing you at your next visit!

Kind regards,

Your Ogden Clinic Health Care Provider

Medicare Annual Wellness Visit Questionnaire

Thank you for choosing Ogden Clinic for your Annual Well Visit. To ensure your medical record is up to date, please complete the entire form.

Patient Demographics

Date: ____

Name: ____

Date of Birth: _____________________________________

Depression Screening

	Not at all	Several days	More than half the days	Nearly every day	OFFICE USE ONLY PHQ-9 YES NO
Over the past two weeks have you felt down, depressed, or hopeless?					
Over the past two weeks have you felt little interest or pleasure in doing things?					

	NO	YES
Are you easily angered?		
Do you feel lonely or socially isolated?		
Do you feel chronically fatigued?		
Do you have chronic pain?		

If you have chronic pain, how would you rate your pain on a scale from 0 to 10? _____

Hearing Screening

Do you wear hearing aids?	
	YES - Skip to the next page ___
	NO - Continue with this section ___

	NO	YES
Do you have a problem hearing over the telephone?		
Do you have trouble following the conversation when two or more people are talking at the same time?		
Do people complain that you turn the TV volume up too high?		
Do you have to strain to understand conversation?		
Do you have trouble hearing in a noisy background?		
Do you find yourself asking people to repeat themselves?		
Do many people you talk to seem to mumble (or not speak clearly)?		
Do you misunderstand what others are saying and respond inappropriately?		
Do you have trouble understanding the speech of women and children?		
Do people get annoyed because you misunderstand what they say?		
Yes to two or more?		

Fall Risk		NO	YES
	Do you feel unsteady when standing or walking?		
	Do you worry about falling?		
	Have you fallen in the past year?		
	If you've fallen in the past year, how many times? ___ One fall ___ More than one fall		
	Were you injured as a result of any falls? ___ No ___ YES		

Safety Screen		NO	YES
	Does the patient's home lack grab bars in the bathroom?		
	Does the patient's home lack handrails on the stairs?		
	Does the patient's home have poor lighting?		
	Does the patient's home have rugs in the hallway?		
	Does the patient wear a seatbelt regularly?		

Functional Ability

What is your current level of activity?

___ Moderate physical activity at work or leisure ___ No limitations
___ Sedentary ___ Wheelchair bound ___ Bed bound
___ Other:

Which of the following best describes your current diet? May choose more than one.

___ Cooks and eats at home regularly ___ Dines out frequently
___ No restrictions - healthy diet ___ Heart Healthy Diet
___ Diabetic diet ___ Vegetarian
___ Lactose intolerant ___ Gluten Free
___ Other:

	NO	YES
Does the patient need help with the phone?		
Does the patient need help with transportation?		
Does the patient need help preparing meals?		
Does the patient need help with housework?		
Does the patient need help with laundry?		
Does the patient need help medications?		
Does the patient need help managing money?		
Does the patient need help with dressing?		
Does the patient need help with feeding?		
Does the patient need help with toileting?		
Does the patient experience incontinence?		
Does the patient need with grooming?		
Does the patient need help with bathing?		
Does the patient need help with getting from bed to chair?		
Does the patient need help with walking across the room (includes cane or walker)?		
Does the patient need help with getting climbing a flight of stairs?		
Does the patient need help shopping?		

Other Providers

Are other providers or suppliers involved in your care?

___ Audiology
___ Cardiology
___ Dermatology
___ Endocrinology
___ Home Health
___ Internal Medicine
___ Medical Supply
___ Nephrology
___ Oncology
Other:
___ Ophthalmology
___ Pain Management
___ Physical Therapy
___ Rheumatology

Living Will / Imms

Do you have a living will? ___Yes ___ No

Please record the last year you had the following. If you do not know, leave blank.

Immunizations	Year	Where
Tetanus		
Pneumococcal		
Influenza		
Shingles		

Health Maintenance

Screening Test	**Year**	**Facility**	**Results**
Colonoscopy			
Other colon cancer screening:			
Mammogram (Females only)			
Pap (Females only)			
Bone Density (DEXA)			
Eye Exam / Glaucoma Screening			
Hepatitis C Screening			
Electrocardiogram (EKG)			
Other: HIV Screening			
Other: Blood Sugar Screening			
Other: Lipid Profile			
Other: PSA (Males only)			

Medical / Surgical History Updates

Please list any **updates to your medical history** of which Ogden Clinic may not have record.
Include any **new medical diagnoses, surgeries, or other tests** that
may have been performed **since your last annual**.

Condition / Surgery / Test	Date