OGDEN CLINIC

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 Wellness Visit.
To ensure your medical record is up to date, please complete the entire form.

Patient Info	
	Date: _____
	Name: _____ **Date of Birth:** _____

Over the past two weeks have you been bothered by any of the following problems?

Depression Screening - PHQ-9	Not at all	Several days	More than half the days	Nearly every day	
Little interest or pleasure in doing things					STAFF: PLEASE USE SMART FORM
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					

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

SDOH	**In the past 12 months have you experienced:**	NO	YES
	Difficulty finding transportation to and from medical appointments?		
	Concerns about a food shortage in your home?		
	Concerns about housing?		
	Problems with unsafe/unclean conditions or utility concerns (electric, water, gas, etc)?		
	Employment concerns and/or financial instability?		
	Instances when you felt unsafe or were harmed?		
	Would you like to receive information on additional support or resources for you or your family members?		

Hearing Screening

Do you wear hearing aids?	YES - Skip to the next section ___ 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		
Are you currently taking any medications considered as blood thinners such as aspirin, Motrin (ibuprofen), Coumadin (Warfarin), Eliquis (apixaban), Xarelto (rivaroxaban), Plavix (clopidogrel)?		

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:

How often do you participate in social activities?

___ One or more times per week ___ One or more times per month ____Less than once per month

Functional Ability		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 with 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 help 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 climbing a flight of stairs?		
	Does the patient need help shopping?		

Other Providers	**Are other providers or suppliers involved in your care?**		
	___ Audiology	___ Internal Medicine	___ Medical Supply
	___ Cardiology	___ Ophthalmology	___ Pain Management
	___ Dermatology	___ Nephrology	___ Physical Therapy
	___ Endocrinology	___ Oncology	___ Rheumatology
	___ Home Health		
	___ Other		___ No other providers

Pain Assessment			NO	YES
	Do you have chronic pain?			
	If you have chronic pain, how would you rate your pain on a scale from 0 to 10? Least Pain <--- 0 1 2 3 4 5 6 7 8 9 10 ---> Most Pain			
	Are you currently taking prescription pain medication known as opioids?	NO - Skip to the next page ___ YES - Continue with this section ___		
	If yes to the above question, please mark any of the following that apply:			
	Family history of substance abuse:	__ Alcohol abuse __ Illegal Drug Abuse __ RX Drug Abuse		
	Personal history of substance abuse:	__ Alcohol abuse __ Illegal Drug Abuse __ RX Drug Abuse		
	Personal history of the following:	__ ADD, OCD, Bipolar, Schizophrenia, Depression		
	Current treatment plan:	__ Managed by PCP __ Managed by pain specialist		
	__ Acupuncture __ Behavioral therapy __ Manipulation therapy __ Massage therapy __ Medical Cannabis __ Physical Therapy __ Pain Contract in Place __ Rehabilitation __ Non-prescription medications: _____			

Health Maintenance

Do you have a living will? ___Yes ___ No

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

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

Immunizations	Year	Where
Tetanus		
Pneumococcal		
Influenza		
Shingles		
COVID-19		Number of doses:

Medical / Surgical History Updates

Which of the following statements best describes your health over the past year?

___ My health has improved ___ My health has stayed the same ___ My health has declined

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 in the **past year**.

Condition / Surgery / Test	Date