Lakeview Clinic Ltd.

Dear Patient,

You have scheduled a Medicare Wellness Visit. We would like you to understand that this visit is not considered an "annual physical" according to Medicare. Medicare does not cover an "annual physical". The components that will be covered today are:

- Depression screening
- Cognitive screening
- Functional ability and safety/fall risk assessment
- Advanced directive discussion
- Listing the members of your health care team
- Outlining future screening tests and needs
- Vital signs

We want to meet your health care needs and expectations.
If you have acute or chronic medical conditions that need to be addressed today, including medication refills, this is not part of the Medicare Wellness Visit. If we have time to address these issues today your provider will bill an additional charge for the treatment of your current and/or existing problems. You will be responsible for any portion of this additional charge that is not usually covered by your Medicare insurance. If there is not time to address these issues today, you may be asked to schedule another appointment to address your other problems/concerns.

Patient Name:_____ Date of Birth:_____

Today's Date:_____

Please complete the following questions below.

General Health

In general, would you say your health this past year has been: Good / Fair / Poor

Dental, Vision, Hearing

Do you see the dentist at least yearly?	Yes No
Do you have any vision problems?	Yes No
Do you have difficulty with your hearing?	Yes No

Lifestyle

Do you eat a healthy diet containing fruits and vegetables every day?	Yes No
Do you exercise regularly?	Yes No
Do you drink alcohol?	Yes No
Do you have concerns about your current weight?	Yes No
Do you currently or have you ever used tobacco?	Yes No
Do you use any illicit drugs?	Yes No
Do you use Marijuana or CBD oils/gummies?	Yes No

Reproductive Health *(female)*

Are you sexually active?	Yes No

Pregnancy History:

Number of pregnancies: _____

Number of live births: _____

Reproductive Health *(male)*

Are you sexually active?	Yes No
Do you experience erectile dysfunction?	Yes No

Functional Ability/Level of Safety

- **Falls Risk Assessment**

Have you fallen in the past year?	Yes No
Do you have difficulty with walking or balance?	Yes No
Do you currently take 5 or more prescription medications?	Yes No

- **Home Safety**

Does your home have loose rugs in your home?	Yes No
Does your home have grab bars in the bathroom?	Yes No
Does your home have railings on the stairs?	Yes No

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- **Activities of Daily Living**
  Do you need help with any of the following?

Bathing or showering	Yes	No
Getting dressed	Yes	No
Using the toilet	Yes	No
Feeding yourself	Yes	No
Getting in or out of bed or chairs	Yes	No
Walking across a room	Yes	No
Climbing stairs	Yes	No

- **Instrumental Activities of Daily Living**
  Do you need help with any of the following?

Shopping for food or clothing	Yes	No
Paying bills or managing money	Yes	No
Preparing meals	Yes	No
Taking your medicines	Yes	No
Doing your housework/laundry	Yes	No
Using the telephone	Yes	No

- **Driving**

Do you drive your own car?	Yes	No
If you drive your own car do you have limitation with your driving (such as driving only in the daylight or only doing local driving)?	Yes	No

Urinary

Do you have any concerns regarding urinary leakage or incontinence?	Yes	No

Advanced Directives

Do you have an Advanced Directive (Living Will)?	Yes	No
Do you have a Durable Power of Attorney?	Yes	No

Other Providers and Medical Equipment/Suppliers

Please list any other medical providers you see on a regular basis (for example: dentist, eye doctor, cardiologist, podiatrist, dermatologist, visiting nurses).

_____

_____

Please list any medical equipment suppliers you use (for example oxygen supplier).

_____

_____

Thank you for completing this questionnaire. Please hand this form to the nurse when you are called into the exam room.