Patient Name_________________________________ Date______________ MRN______________

# Medicare Annual Review and Update

## Review of Past Medical History/ Family History/ Current Medications

If you have an existing electronic medical record in our practice, you will receive a printout of your past medical history, family medical history and list of current medications. Please confirm your personal and family medical history and medications with allergies as recorded on the printed sheets given you from your current medical record or request a worksheet to complete.

## Diet and Activity

List any foods or types of foods you attempt to avoid in your regular daily meals:

_____________________________________________________________________________________

Describe any routine exercise activity, including the type of activity, frequency, and duration or distance:

_____________________________________________________________________________________

## Tobacco and Nicotine

For the tobacco/nicotine products listed below, please indicate whether you have ever been a regular user of each product, and the year started (and quit, if applicable) and the daily amount used:

| Product | Never used | Former user | Current user | Year started | Year Quit | Daily amount used |
|---|---|---|---|---|---|---|
| Cigarettes | ________ | ________ | ________ | _________ | _________ | ______________ |
| Pipe | ________ | ________ | ________ | _________ | _________ | ______________ |
| Cigars | ________ | ________ | ________ | _________ | _________ | ______________ |
| Smokeless | ________ | ________ | ________ | _________ | _________ | ______________ |
| Vaping | ________ | ________ | ________ | _________ | _________ | ______________ |

## Alcohol

| YES | NO | Question |
|---|---|---|
| | | Do you have a current or prior history of alcohol abuse, dependency or alcoholism? |
| | | Do you have a current or prior history of any inappropriate drug use or addiction? |
| | | Have you ever felt you should cut down on your drinking? |
| | | Have people annoyed you by criticizing your drinking? |
| | | Have you ever felt bad or guilty about your drinking? |
| | | Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? |
| *This area reserved for physician: Risk: ___ low ___ other MD Initials/Date:* | | |

### Cognitive Functioning

| Yes | No | Question |
|---|---|---|
| | | Do you have any concerns about your memory or mental capabilities? |
| | | Have family members, friends, caretakers, or others expressed concerns any concerns about your memory? |
| *This area reserved for physician: Does direct observation of the individual contradict the above response? YES NO* | | |


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Patient Name_________________________________ Date______________ MRN______________

### Functional Ability and Level of Safety

| YES | NO | Question |
|---|---|---|
| | | Would you say that you have any difficulty with your hearing? |
| | | Do you need help with bathing, toileting, dressing, eating, or walking? |
| | | Do you use a crutch, cane, walker, wheelchair or other mobility device? |
| | | Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? |
| | | Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? |
| | | Have you had two or more falls within the past 12 months? |
| | | Have you had a fall with injury? |
| | | Do you have any problems with gait or balance? |
| *This area reserved for physician: Does direct observation of the individual contradict the above responses? YES NO* | | |

### End of Life Planning

An Advance Directive is a document defining your end of life planning documenting your wishes in the event that an injury or illness causes you to be unable to make healthcare decisions. If you have an Advance Directive, please leave a copy with your physician so agreement or disagreement with your wishes as expressed in the Advance Directive may be recorded as required by Medicare.
Further information on Advance Directives may be obtained on the Medicare website (www.Medicare.gov) and entering the search term "Advance directives & long-term care", or by going directly to the link www.medicare.gov/manage-your-health/advance-directives/advance-directives-and-long-term-care.html or by phoning Medicare at 1-800-MEDICAR (1-800-633-4227).

| YES | NO | Question |
|---|---|---|
| | | Have you read and understood this regarding further information on Advance Directives? |
| | | Have you appointed a Durable Power of Attorney for Health Care? |
| | | Do you have a Living Will or Advance Directive indicating your end of life planning? |
| | | Have you left a copy of your document today? |
| *To be completed by physician: Do you agree to follow the beneficiary's wishes as expressed in the Advance Directive? YES NO N/A* | | |

## Preventive Services and Recommendations

You are allowed to have a number of screening procedures and counselling, often without additional cost to you, as a component of your Medicare Part B medical insurance. While no one individual would qualify to receive all these services, please read the following information and answer the appropriate questions to find out which tests are appropriate for you. It is beyond the scope of this form to explain in its entirety the Medicare services offered. Find out more at:
http://www.medicare.gov/coverage/preventive-and-screening-services.html
Comprehensive information and advice on each immunization offered below is available by using the search tool on the CDC website: CDC.gov.

Would you like to have a prescription for any of the following vaccinations ordered today? You may take the prescription to a local pharmacy for administration. Always ask, in advance, how much, if any, your co-payment will be for each.

| YES | NO | Vaccination | Date Of Prior |
|---|---|---|---|
| | | Influenza- *if seasonally available both High Dose and regular are available here* | |
| | | Tetanus/whooping cough ("Tdap": tetanus/diphtheria/pertussis)- *once as an adult* | |
| | | Tetanus/diphtheria ("Td")- *once every ten years* | |
| | | Pneumonia: "Prevnar" ("PCV-13")- *no longer advised for most patients after age 65* | |
| | | Pneumonia: "Pneumovax" ("PPV-23")- *at least once after age 65* | |
| | | Shingles: "Shingrix"- (*2 doses after age 50, given 2-6 months apart*) | |
| | | Hepatitis B- *for those at medium or high risk* | |


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Patient Name________________________________ Date______________ MRN______________

Would you like to be scheduled or referred for any of the following tests or exams?

| YES | NO | Screening Test | Date Of Prior |
|---|---|---|---|
| | | Glaucoma- *recommended annually for all over the age of 65, with an ophthalmologist* | |
| | | Colonoscopy- *recommended at least every 10 years to age 80, depending on history, or other screening colon tests as desired, with a gastroenterologist* | |
| | | Lung CT Scan for Current and Former Smokers- *If you are between the ages of 55-77 years and you have smoked more than 30 "pack-years" (where smoking a pack per day for a year equals one pack-year) and are currently smoking or quit less than 15 years ago you may qualify* | |
| | | EKG | |
| | | Female Mammogram- *some now recommended once every other year as a screening test for cancer in women of normal risk without current concerns; others say 1-2 years* | |
| | | DEXA scan for osteoporosis screening- *may be covered by Medicare every two years if a history of osteopenia, osteoporosis, related fractures, or other risks. Many authorities recommend this screening even in situations not covered by Medicare* | |
| | | Female breast exam- *no longer recommended as a screening test for cancer in women of normal risk without current concerns, with a gynecologist* | |
| | | Female Pap smear- *no longer recommended after the age of 65 as a screening test for cancer in women of normal risk without current concerns, with a gynecologist* | |
| | | Male digital rectal exam for prostate cancer- *no longer recommended as a screening test for cancer in men of normal risk without current concerns* | |
| | | Abdominal Aortic Aneurysm (AAA) Screening-*an ultrasound test which may be covered during your first year on Medicare and which is recommended once for those with a family history of AAA or men who have smoked more than 100 cigarettes* | |

Would you like to have any of the following blood tests ordered today?

| YES | NO | Blood Test | Date Of Prior |
|---|---|---|---|
| | | Glucose (sugar)- *may help screen for diabetes, if not done in the past three months* | |
| | | Cholesterols- *a major risk factor for heart disease, if not done in the past three months* | |
| | | Hepatitis C-*recommended once for all those born 1945-1965* | |
| | | PSA (for prostate cancer)- *annually or less, per various authorities, up to age 70* | |
| | | HIV- *for those at increased risk or those who wish to know their status* | |
| | | Other sexually transmitted diseases: chlamydia, gonorrhea, syphilis and/or Hepatitis B- *if at increased risk for disease* | |

Would you like to be scheduled or referred for counseling for any of the following conditions?

| YES | NO | Medical Condition |
|---|---|---|
| | | Sexually Transmitted Infections- *review of risky behavior which may increase your likelihood of disease* |
| | | Tobacco use- *a series of brief office visits to assist and document ongoing efforts to quit tobacco use* |
| | | Alcohol misuse- *if you are misusing alcohol, you may qualify for four counseling sessions per year* |
| | | Cardiovascular Disease- *a separate office visit to assess blood pressure, review diet habits and medicine* |
| | | Obesity (BMI>30)- *counselling and tracking of weight loss* |
| | | Nutrition Therapy- *for patients with diabetes or kidney disease, or patients who have had a kidney transplant in the last 36 months* |

Finally, please review to be certain that you have answered all responses where appropriate.
If so, you have completed this form.

Physician signature after notation by the physician supplementing and confirming this information as indicated above and/or recorded in the electronic medical record document created on this date;


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# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________________________ DATE:____________________

| Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle or check each answer) | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure 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. Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| | add columns | + | + | |
| | TOTAL: | | | |

| 10. If you checked off any problems, how difficult have these 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 | ________ |

__none0__minimal4__mild9__moderate14__moderately severe19__severe__on therapy Physician review: I have reviewed this information, with appropriate notation supplementing and/or confirming the information recorded. __________________________________ David L. Anders, MD

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# REPORT OF COGNITION AND FUNCTION

Patient Name_____________________________________________ Date__________________

As reported by: _____________________________Relationship to patient: ______________20190408

Circle the number which best approximates the current status of each task or behavior on the scale from "Always" ("10") to "Never" ("1"). Reply "N/A" if not applicable (i.e. if that task has never been performed).

| **Tasks and Behaviors** | **Always......Often.....Sometimes......Never** | **N/A** |
|---|---|---|
| *F*orgets where things were put | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Has difficulty finding the correctword | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Forgets names of known acquaintances | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Self-reports concerns about a decrease in memory | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| *A* decrease in function has been noted at work by co-workers | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Unable to travel alone to unfamiliar location | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| *F*orgets to pay bills or difficulty with checkbook | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Recent citation for accident or ticket for moving violation | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Has gotten lost while driving | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Difficulty managing own medications | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Difficulty with shopping | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Difficulty preparing standard meal | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Difficulty maintaining a clean house or apartment interior | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Difficulty operating a telephone | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Difficulty in doing laundry | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| *R*equires help selecting proper clothing for season, occasion | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Less attention to appearance (hair style, shaving, cleanliness) | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| *D*ifficulty dressing without assistance | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Unable to bathe properly without assistance | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Unable to properly use toilet (flush tissue and waste, wipe) | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Forgets name of spouse or children | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Urinary incontinence occurs | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Fecal (bowel movement) incontinence occurs | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Voices desire to go "home" to a place and time in the past | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Unable to remember which family members have died | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Changed personality with increased aggression or agitation | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Hallucinations or wildly vivid dreams reported | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Requires cane or walker to move about | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Cannot go from bed to chair to bed without assistance | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| *S*peech is limited to the use of six different words per day | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Speech is limited to the use of one intelligible word daily | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Cannot walk without personal assistance | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Cannot sit upright in chair without supports | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Unable to feed self | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Unable to smile | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |
| Unable to lift head or hold head up | 10.....9.....8.....7.....6.....5.....4.....3.....2.....1.....0 | _____ |

Physician signature after notation by the physician supplementing and confirming this information as indicated above and/or recorded in the electronic medical record document created on this date:

Patient Name________________________________ Date______________ MRN______________

**Education, Counseling, & Referral: Summary of Your Medicare Annual Review**

Findings in today's screening were:

Weight_____ lbs Height_____ in. Blood Pressure__________ Body Mass Index ________

Vision-left__________ Vision-right__________

The list of recommended or selected Medicare screenings is summarized below as indicated by a "√" in the first column of the possible screenings. You may wish to reconsider others by reviewing information at: http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/downloads/MPS_QuickReferenceChart_1.pdf

| √ | Procedure | Notes |
|---|---|---|
| | Abdominal Aortic Aneurysm Screening | |
| | Alcohol Misuse Screening and Counseling | |
| | Bone Mass Measurement (Bone Density Test) | *Ongoing every 2-5 years* |
| | Cardiovascular Disease (Behavioral Therapy) | |
| √ | Cardiovascular Screenings (cholesterol, lipids, triglycerides) | *Ongoing every 1-5 years* |
| √ | Colorectal Cancer Screenings | |
| | Depression Screening | *Ongoing and report any concerns* |
| √ | Diabetes Screening | *Ongoing every 1-5 years* |
| | Diabetes Self-management Training | |
| √ | Glaucoma Testing | *At least annually* |
| | HIV Screening | |
| | Mammogram | *Every 1-2 years until at least 80 yrs.* |
| | Medical Nutrition Therapy Services | |
| √ | Obesity Screening and Counseling | *Ongoing with every visit* |
| | Pap Test, Pelvic and Breast Exam | *No longer advised after 65 years* |
| | Prostate Cancer Screening | *No longer advised after 65 years* |
| | Sexually Transmitted Infections Screening and Counseling | |
| | Tobacco Use Cessation | |
| √ | Flu Shot | *Ongoing annually* |
| | Tetanus Shot (Tdap: tetanus, diphtheria and pertussis) | |
| | Pneumonia Shot (Pneumovax) | |
| | Shingles ("Shingrix") (Primary and Booster) | Two doses 2-6 months apart |

The "Guide to Medicare's Preventive Services" has more information about these and other preventive services, including costs and conditions that may apply. Visit **Medicare.gov/publications** Based on today's findings, you may also wish to consider the following opportunities to further enhance the benefits of today's evaluation (as indicated by a "√"). Websites listed should be searched for topics listed in **bold** font:

| √ | Opportunity | Notes |
|---|---|---|
| √ | Plan for an annual Medicare "**Wellness Visit**" one year from now | More info at www.Medicare.gov |
| √ | Maintain a **body mass index** between 18.5 to 24.9 | More info at www.cdc.gov/az/ |
| √ | Maintain a **blood pressure** below 120/80 | More info at www.cdc.gov/az/ |
| √ | Engage in **physical activity** appropriate for your condition | More info at www.cdc.gov/az/ |
| | Obtain an **Advance Directive (AD)** | More info at www.Medicare.gov |
| | Consider sending a copy of your AD for your medical record | |
| | Send us a complete list of all medications for your medical record | |
| | Address safety issues in your home to prevent **falls** | More info at www.cdc.gov/az/ |
| Referrals and Other: | | |
| | | |
| Physician signature: | | |


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