



Patient Name: _____

Date of Birth: _____

607 Highway 466
Lady Lake, FL 32159
(352) 259 - 7994

You are scheduled for your Medicare Annual Wellness Visit on ____ / ____ / ____ at ____ : ____ AM/PM with:

- Dusk R. Gosney, DO
- Karen Callahan, DNP
- Ron Kope, APRN
- Georgina Boardley, PA-C

Please arrive to the clinic with your completed forms (attached) no later than 15 minutes prior to your appointment time. These forms are also available to print on our website, www.theburrnessmedicalcenter.com. Bring all of your current insurance cards and a photo ID. Please review the details of this visit below.

What should I expect at my appointment?

Your appointment will last about 30 minutes. The first 20 minutes will be spent with a Medical Assistant reviewing preventative services (see below for details) and developing or updating a personalized wellness plan to help prevent disease or disability based on your current health and risk factors. The final 10 minutes will be spent with your provider reviewing and validating your personalized plan with you. The “Annual Wellness Visit” is not a physical exam.

How much does the visit cost?

Medicare covers 100% of the visit but it ONLY covers preventative services. Please see below for details regarding this.

What does “preventative services” mean?

Medicare sets guidelines on what these services can include. Please see below:

- Vitals measurement
- Personal medical/surgical history
- Family medical history
- Immunization history
- Current providers (i.e. specialists)
- Screening services you may be eligible for (i.e. mammogram, pap smear, colonoscopy, blood sugar, cholesterol, bone density, etc.) and written lists of what services you need
- Personalized health advice
- Discussion about advanced directives
- Smoking cessation counselling, if indicated

What services are NOT covered by an Annual Wellness Visit?

- A full physical exam
- Acute illnesses (i.e. rashes, colds, pain, earaches, ear flushes, etc.)
- Chronic disease management (i.e. diabetes, blood pressure, cholesterol, etc.)
- Medication questions or changes
- Lab review

What should I do if I have things to discuss that are not covered by a Medicare Annual Wellness Visit?

Please schedule a separate appointment to discuss specific health care concerns with your provider. If other issues are discussed during this visit, you may have to pay towards your Medicare Part B deductible and/or coinsurance. Please check with your insurance prior to your appointment if you have questions regarding what is covered. Visit [medicare.gov/coverage/yearly-wellness-visits](https://www.medicare.gov/coverage/yearly-wellness-visits) for more information.

Is the Medicare Annual Wellness Visit mandatory?

Although it is highly recommended, it is not mandatory to maintain your Medicare Part B coverage.

Please call us at (352) 259 - 7994 if you have questions about your upcoming appointment.

Thank you,

Lady Lake Family Medicine

Social Determinants of Health Screening Tool

Living Situation

1. What is your living situation today?
- I have a steady place to live
 - I have a place to live today, but I am worried about losing it in the future
 - I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. Think about the place you live. Do you have problems with any of the following?

CHOOSE ALL THAT APPLY

- Pests such as bugs, ants, or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above

Food

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true
- Sometimes true
- Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- Often true
- Sometimes true
- Never true

Utilities

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- Yes
- No
- Already shut off

Transportation

5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- Yes
- No

Safety

7. How often does anyone, including family and friends, physically hurt you?

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

8. How often does anyone, including family and friends, insult or talk down to you?

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

9. How often does anyone, including family and friends, threaten you with harm?

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

10. How often does anyone, including family and friends, scream or curse at you?

- Never
- Rarely
- Sometimes
- Fairly often
- Frequently

Controlled Substance Abuse Risk Assessment Tool

Circle the number that corresponds to your specific situation. Only circle those numbers in the column that pertains to the gender you identify with.

Mark each box that applies	Female	Male
Family History of Substance Abuse		
Alcohol	1	3
Illegal drugs	2	3
Prescription Drugs	4	4
Personal History of Substance Abuse		
Alcohol	3	3
Illegal drugs	4	4
Prescription Drugs	5	5
Age Between 16 – 45	1	1
History of Pre-adolescent Sexual Abuse	3	0
Psychological Disease		
Attention Deficit Disorder, Obsessive-Compulsive Disorder, Schizophrenia	2	2
Depression	1	1
Scoring Total		

A score of 3 or lower indicates low risk for future opioid abuse, a score of 4-7 indicates a moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Please complete the following questions to the best of your ability.

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted?
 - Not at all
 - Slightly
 - Moderately
 - Quite a bit
 - Extremely
2. During the past 4 weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
 - Not at all
 - Slightly
 - Moderately
 - Quite a bit
 - Extremely
3. During the past 4 weeks, how much bodily pain have you generally had?
 - No pain
 - Very mild pain
 - Moderate pain
 - Severe pain
4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.
 - Yes, as much as I wanted
 - Yes, quite a bit
 - Yes, some
 - Yes, a little
 - No, not at all
5. What was the hardest physical activity you could do for at least 2 minutes?
 - Very heavy
 - Heavy
 - Moderate
 - Light
 - Very light
6. Can you shop for groceries or clothes without help?
 - Yes
 - No
7. Can you prepare your own meals?
 - Yes
 - No
8. Can you do your own housework without help?
 - Yes
 - No
9. Can you handle your own money without help?
 - Yes
 - No
10. Do you need help eating, bathing, dressing, or getting around your home?
 - Yes
 - No
11. Can you get to places that are out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?
 - Yes
 - No
12. During the past 4 weeks, how would you rate your health in general?
 - Excellent
 - Very good
 - Good
 - Fair
 - Poor
13. How have things been going for you during the past 4 weeks?
 - Very well - could hardly be better
 - Pretty good
 - Good and bad parts about equal
 - Pretty bad
 - Very bad - could hardly be worse
14. Are you having difficulties driving your car?
 - Often
 - Sometimes
 - No
 - Not applicable, I do not use a car

15. Do you always fasten your seatbelt when you are in a car?

- Always
- Sometimes
- Never

16. How often during the past 4 weeks have you been bothered by any of the following problems? 1=Never; 2=Seldom; 3=Sometimes; 4=Often; 5=Always

Fall or dizzy when standing up

[1] [2] [3] [4] [5]

Sexual problems

[1] [2] [3] [4] [5]

Trouble eating well

[1] [2] [3] [4] [5]

Trouble with teeth or dentures

[1] [2] [3] [4] [5]

Problems hearing on the telephone

[1] [2] [3] [4] [5]

Feeling tired or fatigued

[1] [2] [3] [4] [5]

17. Do you exercise for about 20 minutes 3 or more days a week?

- Yes, most of the time
- Yes, some of the time
- No, I usually do not exercise this much

18. Have you been given any information to help you with the following:

Hazards in the house that might hurt you?

- Yes
- No

Keeping track of your medications?

- Yes
- No

19. How confident are you that you can control and manage most of your health problems?

- Very confident
- Somewhat confident
- Not very confident
- I do not have any health problems

20. How often do you have trouble taking medications the way you've been told to take them?

- I do not take prescription medications
- I always take them as prescribed
- I often take them as prescribed
- I sometimes take them as prescribed
- I seldom take them as prescribed

21. Have you used any prescription medication(s) just for the feeling, more than prescribed, or that were not prescribed to you?

- Yes
- No

22. Do you feel unsteady when walking or standing?

- Yes
- No

23. Do you worry about falling?

- Yes
- No

24. Do you have stairs in your home?

- Yes
- No

25. Do you have rugs in your home?

- Yes
- No

26. Do you have pets in your home?

- Yes
- No

27. Do you take a daily Aspirin?

- Yes
- No

28. Have you fallen in the past year?

- Yes
- No

29. If you answered yes to question 28, how many times? _____

30. If you answered yes to question 28, were you injured?

- Yes
- No

Patient Health Questionnaire – 9

Over the past 2 weeks, how often have you been bothered by any of the following problems?

(Circle your answers)	Not at all	Several days	More than half the days	Nearly everyday			
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 in some way	0	1	2	3			
For office coding:	0	+	_____	+	_____	+	_____
Total: _____							

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

Pain Assessment

Have you experienced any pain in the last 2 weeks? Yes No

If yes, please fill out the form below:

<p>Intensity</p> <p>Question: On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine, how much does it hurt right now?</p> <div style="text-align: center;"> </div> <p>Please mark one of the options above. N/A is not a valid response.</p>	<p>Pain Score</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<p>Location</p> <div style="text-align: center;"> </div>
<p>Is this pain constant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Type of pain (Example: ache, deep, sharp, hot, cold, sensitive skin):</p>	
<p>Onset, duration, variations:</p>	<p>What relieves the pain?</p>	
<p>What causes or increases the pain?</p>	<p>Treatment plan:</p>	
<p>Other comments:</p>		
<p>Signature</p>	<p>Date</p>	

Preventative Health Questionnaire

Colon Cancer Screening

Colonoscopy:

Have you ever had a colonoscopy? Yes No

Date/Year last performed: _____ Where was this study performed: _____

Results: Unknown Normal Abnormal Other: _____

Cologuard:

Have you ever used Cologuard? Yes No

Date/Year last performed: _____

Results: Unknown Normal Abnormal Other: _____

Breast Cancer Screening

Mammogram:

Have you ever had a mammogram? Yes No

Date/Year last performed: _____ Where was this study performed: _____

Results: Unknown Normal Abnormal Other: _____

Cervical Cancer Screening

Pap Smear:

Have you ever had a pap smear? Yes No

Date/Year last performed: _____ Where was this study performed: _____

Results: Unknown Normal Abnormal Other: _____

Osteoporosis Screening

Dual-Energy X-ray Absorptiometry (DEXA):

Have you ever had a DEXA? Yes No

Date/Year last performed: _____ Where was this study performed: _____

Results: Unknown Normal Abnormal Other: _____

Lung Cancer Screening

Low-Dose Chest CT:

Have you ever had a low-dose chest CT? Yes No

Date/Year last performed: _____ Where was this study performed: _____

Results: Unknown Normal Abnormal Other: _____

Abdominal Aortic Aneurysm (AAA) Screening

AAA Ultrasound:

Have you ever had an AAA ultrasound? Yes No

Date/Year last performed: _____ Where was this study performed: _____

Results: Unknown Normal Abnormal Other: _____

Vaccines

Influenza (Flu): Have you ever received the flu vaccine?

Yes No Unknown

Date last received? _____

Pneumonia: Have you ever received the pneumonia vaccine?

Yes No Unknown

Date last received? _____

Shingles: Have you ever received the Shingles vaccine?

Yes No Unknown

Date last received? _____

Tetanus: Have you ever received the Tetanus vaccine?

Yes No Unknown

Date last received? _____

Respiratory Syncytial Virus (RSV): Have you ever received the RSV vaccine?

Yes No Unknown

Date last received? _____

Tobacco Screening

Do you currently use tobacco products?

Current tobacco use:

How many packs / cigars / time spent vaping do you spend daily? _____

How long have you smoked this amount? _____

Former tobacco use:

How many packs / cigars / time spent vaping did you spend daily? _____

How long did you smoke this amount? _____

When did you quit? _____

I have never used tobacco products

For Patients with Diabetes Only

Dilated Eye Exam:

Have you ever had a dilated eye exam? Yes No

Date/Year last performed: _____ Where was this performed: _____

Results: Unknown Normal Abnormal Other: _____

Diabetic Foot Exam:

Have you ever had a foot exam? Yes No

Date/Year last performed: _____ Where was this performed: _____

Results: Unknown Normal Abnormal Other: _____

Hemoglobin A1c:

Have you ever completed A1c testing? Yes No

Date/Year last performed: _____

Results: Unknown A1c: _____