Wayland Medical Associates
160 Wayland Avenue, Providence RI 02906
Phone (401) 521-1221 Fax (401) 454-4189

Dear Valued Patient:

Your Medicare insurance coverage pays for an Annual Wellness Visit. ***There is no cost to you, even if you haven't met your deductible.*** This is not the same thing as a yearly physical. The Annual Wellness Visit focuses on gathering your health information and counseling you on improving your health and preventing complications from any illnesses you may currently have and maintaining your overall health and wellness.

At this visit, your provider will talk to you about your medical history, review your risk factors and provide a personalized preve3ntion plan to keep you healthy. We will also look at opportunities that are available to you to help you stay healthy and /or address any barriers you are having with your health care. In addition to your provider and medical assistants, our team includes a nurse care manager and pharmacist that are here to assist you.

The information in this enclosed packet is required by Medicare. Please complete and return it with you on your scheduled appointment. We appreciate the trust you put in us to take care of your health care needs and hope you take advantage of this benefit to work with your provider in creating your personalized prevention plan.

Sincerely,

Dr Richard Ruggieri

Dr Geoffrey Berg

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Medicare Annual Wellness Visit

Patient Name: _____ **DOB:** _____

Appointment Date and Time: _____

1.) In general, would you say your health is?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

2.) In general, would you say your quality of life is?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

3.) In general, how would you rate your physicial health?

- ☐ Excellent
- ☐ Very Good

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- ☐ Good
- ☐ Fair
- ☐ Poor

4.) In general, how would you rate your mental health, including your mood and ability to think?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

5.) In general, how would you rate your satisfaction with your social activities and relationships?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

6.) In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, work, in your community and responsibilities as a parent, spouse, friend etc.)

- ☐ Excellent
- ☐ Very Good

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- ☐ Good
- ☐ Fair
- ☐ Poor

7.) To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries or moving a chair?

- ☐ Completely
- ☐ Mostly
- ☐ Moderately
- ☐ A Little

8.) In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

9.) In the past 7 days, how would you rate your fatigue on average?

- ☐ None
- ☐ Mild
- ☐ Moderate

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- ☐ Severe
- ☐ Very Severe

10.) In the past 7 days, how would you rate your pain on average?

- ☐ 0 (No Pain)
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 (Worst Pain Imaginable)

11.) Do you take any medications for pain more than twice per week?

- ☐ Yes
- ☐ No

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12.) Have you had any difficulties walking a quarter of a mile (400 meters)?

- ☐ No or some difficulties
- ☐ A lot of difficulties

13.) Have you had any difficulties climbing up a flight of stairs?

- ☐ No or some difficulties
- ☐ A lot of difficulties

14.) During the last year, have you involuntarily lost more than 10 pounds?

- ☐ No
- ☐ Yes

15.) How often in the last week did you feel that everything you did was an effort or that you could not get going?

- ☐ Rarely or sometimes (2 times or less per week)
- ☐ Often or almost always (3 or more times per week)

16.) Which is your level of physical activity?

- ☐ Regular physical activity (At least 2-4 hours per week)
- ☐ None or mainly sedentary

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

17.) Little interest or pleasure in doing things?

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- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

18.) Feel down, depressed or hopeless?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

19.) Trouble falling/staying asleep or sleeping too much?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

20.) Feeling tired or having little energy?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

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21.) Poor appetite or overeating?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

22.) Feeling bad about yourself or that you are a failure, let your family or yourself down?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

23.) Trouble concentrating on things; such as reading newspaper or watching television?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

24.) Moving or speaking so slowly that people notice? Being so fidgety or restless that you are moving around a lot more than usual?

- ☐ Not at all

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- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

25.) Thoughts you would be better off dead or hurting yourself in some way?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

26.) 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

Over the last two weeks, how often have you been bothered by the following problems?

27.) Feeling nervous, anxious or on edge?

- ☐ Not at all

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- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

28.) Not being able to stop or control worrying

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

29.) Difficulty relaxing or being so restless that it is hard to sit still?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

30.) Becoming easily annoyed or irritated?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

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31.) Feelings of doom; as if something awful may happen?

- ☐ Not at all
- ☐ Several Days
- ☐ More than half the days
- ☐ Nearly every day

32.) Have you ever felt you ought to cut down on your drinking or drug use, if applicable?

- ☐ Yes
- ☐ No
- ☐ N/A

33.) Have people annoyed you by criticizing you're drinking or drug use?

- ☐ Yes
- ☐ No

34.) Have you ever felt bad or guilty about your drinking or drug use?

- ☐ Yes
- ☐ No

35.) Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?

- ☐ Yes

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☐ No

36.) How many standard drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 to 2

☐ 3 to 4

☐ 5 to 6

☐ 7 to 9

☐ 10 or more

37.) How often do you have six or more drinks on one occasion?

☐ Never

☐ Less than monthly

☐ Monthly

☐ Weekly

☐ Daily or almost

38.) In the past 12 months, have you felt unsteady when standing or walking?

☐ Yes

☐ No

39.) In the past 12 months, have you had worries about falling?

☐ Yes

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☐ No

40.) In the past 12 months, have you fallen? If so, how often?

☐ Yes How often? _____

☐ No

41.) Were you injured as a result of a fall in the past 12 months?

☐ Yes How Severe? _____

☐ No

42.) Do you have difficulty doing any of the following activities due to health/physical problems?

☐ Bathing

☐ Dressing

☐ Feeding

☐ Maintaining continence

☐ Transferring (getting up and down from seated position ie, chair, toilet etc)

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43.) In the past 4 weeks, did you need help to take care of any of the following activities? Please check all that apply

- ☐ Housekeeping (light cleaning and vacuuming)
- ☐ Laundry
- ☐ Managing Finances (banking and paying bills)
- ☐ Meals
- ☐ Shopping
- ☐ Managing Medications (taking at correct time, requesting refills, pill count, etc)
- ☐ Transportation (to and from appointments and shopping)
- ☐ Using the Telephone

44.) If you drive, do you feel that driving a car is difficult for you?

- ☐ Yes
- ☐ No

45.) Do you feel safe while driving?

- ☐ Yes
- ☐ No

46.) How often do you use a seat belt when you drive or ride in a car?

- ☐ Always
- ☐ Nearly Always

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- ☐ Sometimes
- ☐ Seldom
- ☐ Never use a seat belt

47.) If you do not drive, do you have reliable transportation for shopping, appointments and visiting with family and friends?

- ☐ Yes
- ☐ No

48.) Do you smoke or use other tobacco products?

- ☐ Yes
- ☐ No

49.) Are you sexually active?

- ☐ Yes
- ☐ No

50.) Do you have difficulty or pain with sexual activities?

- ☐ Yes
- ☐ No

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51.) Do you have concerns about your weight?

- ☐ Yes
- ☐ No

52.) Do you have any tooth/mouth problems that make it difficult or painful to eat?

- ☐ Yes
- ☐ No

53.) As you move from room to room in your house, do you slip or stumble from clutter of electrical cords, low furniture or other things in your path?

- ☐ Never
- ☐ Rarely
- ☐ Once per week
- ☐ More than once per week

54.) Do you have a medical alert system that helps you alert help if you should fall, need an ambulance or get locked out of your home?

- ☐ Yes
- ☐ No

55.) Do you have a smoke detector and carbon monoxide detector?

- ☐ Smoke Detector and Carbon Monoxide
- ☐ Smoke Detector only

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- ☐ Carbon Monoxide only
- ☐ Neither
- ☐ Do not know

56.) Do you have concerns about your memory?

- ☐ Yes
- ☐ No

57.) How many hours of sleep do you typically get?

- ☐ Less than 6 hours
- ☐ 6-8 hours
- ☐ 9 hours or more

58.) In the past 7 days, how often have you felt sleepy during the daytime?

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

59.) Has anyone told you that you snore?

- ☐ Yes

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☐ No

60.) Do you have trouble hearing in a crowded area?

☐ Yes

☐ No

61.) Do you have trouble with your vision or seeing?

☐ Yes

☐ No

62.) Many people experience issues with urinary incontinence (leakage of urine). Do you ever leak urine when you do not want to?

☐ Always

☐ Usually

☐ Sometimes

☐ Rarely

☐ Never

63.) In the past 7 days, how often have you experienced bowel constipation or urgency with accident?

☐ Daily

☐ More than 4 times

☐ Fewer than 3 times

☐ Never

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64.) Do you have enough money to purchase things you need to live every day, ie food, housing, clothing?

- ☐ Yes
- ☐ Sometimes
- ☐ No

65.) How confident are you in filling out medical forms without help?

- ☐ Extremely
- ☐ Very
- ☐ Somewhat
- ☐ Rarely

66.) How confident are you in managing most of your health issues?

- ☐ Extremely
- ☐ Very
- ☐ Somewhat
- ☐ Rarely

Thank you for completing this survey!