To: Our Medicare Patients
Subject: Medicare Initial Preventive Physical Exam and Annual Wellness Visits

Beginning January 1, 2011, Medicare covers an “Annual Wellness Visit” in addition to the one-time “Initial Preventive Physical Exam.” The “Initial Preventive Physical Exam” occurs only once during your first twelve months as a Medicare patient. You may receive your Annual Wellness Visit after you have been with Medicare for more than one year, or it has been at least one year since your “Initial Preventive Physical Exam” exam.

<table>
<thead>
<tr>
<th>Initial Preventive Physical Exam (IPPE)</th>
<th>“Initial Preventive Physical Exam” is only for new Medicare patients. This must be done in the 1st year as a Medicare patient.</th>
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<tbody>
<tr>
<td>Annual Wellness Visit, Initial</td>
<td>At least 1 yr after the “Initial Preventive Physical Exam.”</td>
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<td>Annual Wellness Visit, Subsequent</td>
<td>Once a year (more than 1 yr + 1 day after the last Wellness Visit).</td>
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The Annual Wellness Visit is not the same thing as what many people often refer to as their yearly physical exam. Medicare is very specific about what the “Annual Wellness Visit” includes and excludes.

At the Annual Wellness Visit, your physician or non-physician provider will talk to you about your medical history, review your risk factors, and make a personalized prevention plan to keep you healthy. The visit does not include a hands-on exam or any testing that your doctor may recommend, or include any discussion about any new or current medical problems, conditions, or medications. You may schedule another visit to address those issues or your doctor may charge the usual Medicare fees for such services that are beyond the scope of the Annual Wellness Visit.

If you would like to schedule an annual physical, including any lab work or other diagnostic testing, medication management, vaccinations, and other services, please understand that these services will be charged and covered according to Medicare’s usual coverage guidelines. However, you may still develop a care plan based on the Annual Wellness Visit criteria.

We appreciate the trust you put in us to take care of your health care needs and hope that you will take advantage of this new benefit to work with your physician in creating your personalized prevention plan.

**Please see the attached list to bring with you to your appointment**
Please complete this form for your Initial Preventive Physical Exam:

The names of all your doctors:

<table>
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<tr>
<th>Name of doctor</th>
<th>Specialty</th>
<th>Name of doctor</th>
<th>Specialty</th>
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A list of all your medications, vitamins and supplements:

<table>
<thead>
<tr>
<th>Name of Medicine, Vitamin, and/or Supplement</th>
<th>Dose</th>
<th>How Medication or Supplement is Taken (1 daily, twice daily, as needed, etc.)</th>
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Have you had any tests done in the past year?  ____ Yes  ____ No
If yes, please provide dates below

<table>
<thead>
<tr>
<th>Test Name</th>
<th>Date</th>
<th>Test Name</th>
<th>Date</th>
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<tbody>
<tr>
<td>Eye Exam</td>
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<td>X-Ray</td>
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<td>Dental Exam</td>
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<td>CT Scan</td>
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<tr>
<td>Mammogram</td>
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<td>MRI</td>
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<tr>
<td>Bone Density (DXA)</td>
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<td>EKG (stress test)</td>
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<td>Colonoscopy</td>
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<td>Cholesterol Screening</td>
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<tr>
<td>Pap Smear</td>
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<td>Diabetes Screening</td>
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Have you had any recent immunizations?  ____ Yes  ____ No

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<thead>
<tr>
<th>Immunization</th>
<th>Date</th>
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A Checklist for Your Medicare Annual Wellness Visit

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health care possible. If you have an advanced directive or living will, please provide us with a copy.

1. How have things been going for you in the past 4 weeks?
   □ Very well – could hardly be better
   □ Pretty good
   □ Good and bad are about equal
   □ Pretty bad
   □ Very bad – could hardly be worse

2. During the past 4 weeks, how would you rate your general health?
   □ Excellent
   □ Very good
   □ Good
   □ Fair
   □ Poor

3. 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

4. Do you live with someone?
   □ Yes Name and Relationship: _____________________
   □ No

5. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or sad, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or need help taking care of yourself.
   □ Yes, as much as I wanted
   □ Yes, quite a bit
   □ Yes, some
   □ Yes, a little
   □ No, not at all

6. During the past 4 weeks, has your physical and emotional health limited your social activities with family, friends, neighbors or social groups?
   □ Not at all
   □ Slightly
   □ Moderately
   □ Quite a bit
   □ Extremely

7. Over the past 2 weeks, have you experienced having little interest or pleasure in doing things?
   □ Yes □ No

   Over the past 2 weeks, have you been feeling down, depressed or hopeless?
   □ Yes □ No

8. Do you always fasten your seatbelt when you are in a car?
   □ Yes, Always
   □ Yes, Sometimes
   □ No

9. Do you smoke cigarettes or use other types of tobacco products?
   □ No
   □ Yes, and I might quit
   □ Yes, but I am not ready to quit
10. Did you have a drink containing alcohol in the past year?

- □ No, I don’t drink alcohol
- □ Yes, 0-1 drink every month
- □ Yes, 2-4 drinks every month
- □ Yes, 2-3 drinks every week
- □ Yes, 4 or more drinks every week

11. Have you had sex in the past 12 months?

- □ Yes  □ No

Have you ever had a sexually transmitted disease?

- □ Yes  □ No

12. Yes  No

- □ □ Can you prepare your own meals?
- □ □ Do you need help eating, bathing, dressing, or getting around your home?
- □ □ Can you use the telephone without help?
- □ □ Can you shop for groceries or clothes without help?
- □ □ Can you do your own housework and laundry without help?
- □ □ Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?
- □ □ Can you handle your own money without help?
- □ □ Are you having difficulties driving your car?

13. Yes  No

- □ □ Have throw rugs been removed or fastened down?
- □ □ Are electrical cords in good repair, especially on heating pads?
- □ □ Are working smoke detectors present (at least one on each level of home)?
- □ □ Are emergency telephone numbers posted by the phone and regularly updated?
- □ □ Are handrails installed beside the tub and toilet?
- □ □ Are non-slip mats in all bathtubs and/or showers?
- □ □ Are electrical outlets and appliances a safe distance from the tub?
- □ □ Are there raised or uneven places on the sidewalk?
- □ □ Are stairs in good repair?
- □ □ Are handrails securely fastened?

14. How often do you have trouble taking medicines the way you have been told to take them?

- □ I do not have to take medicine
- □ I always take them as prescribed
- □ Sometimes I take them as prescribed
- □ I seldom take them as prescribed

15. How often in the past 4 weeks have you had trouble eating well? For example, if you had trouble chewing, swallowing or a poor appetite.

- □ Never
- □ Seldom
- □ Sometimes
- □ Often
- □ Always

16. How often in the past 4 weeks, have you been bothered by your teeth or dentures?

- □ Never
- □ Seldom
- □ Sometimes
- □ Often

17. On a typical day, how many servings of high fiber or whole grain food do you eat? (1 serving = 1 slice of whole wheat bread, 1 cup of whole grain or high fiber cereal, ½ cup of oatmeal, brown rice or whole wheat pasta)

- □ None
- □ 1-2 servings
- □ 2-3 servings
- □ ≥ 4 servings
18. On a typical day, how many servings of fried or high-fat foods do you eat? (Such as fried chicken, french fries, potato chips, corn chips, doughnuts and creamy salad dressings)

- None
- 1-2 servings
- 2-3 servings
- ≥ 4 servings

19. On a typical day, how many servings of fruits and vegetables do you eat? (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit)

- None
- 1-2 servings
- 2-3 servings
- ≥ 4 servings

20. How many sugar-sweetened beverages do you typically drink each day

- None
- 1-2
- 2-3
- ≥ 4 servings

21. In the past 7 days, how many days did you exercise?

- I am not currently exercising
- 1-2 days
- 3-4 days
- 5-6 days
- 7 days

22. On days when you exercised, how long did you exercise?

- 5-10 minutes
- 10-15 minutes
- 15-30 minutes
- 30-60 minutes

23. How intense was your typical exercise?

- Light (like stretching or slow walking)
- Moderate (like brisk walking)
- Heavy (like jogging or swimming)
- Very heavy (like fast running or stair climbing)

24. Yes No

- □  □  Are you afraid of falling?
- □  □  Have you fallen in the past year?
  If yes, how many times have you fallen? ______
- □  □  If yes, were you injured when you fell?

25. Yes No

- □  □  Do you have problems hearing over the telephone?
- □  □  Do others complain that you turn radio and TV volumes too high?
- □  □  Do you strain to understand conversation?
- □  □  Do you often ask people to repeat themselves?
- □  □  Do you have trouble hearing over a noisy background?
- □  □  Do you have problems with your hearing?

26. Yes No

- □  □  Do you have a Healthcare Power of Attorney?
  If yes, please provide name and relationship ________________________________
- □  □  Do you have an Advance Directive?
- □  □  Do you have a Living Will?
- □  □  Are you willing to discuss end-of-life planning today?