



Carolinus HealthCare System

Dear Patient,

Thank you for scheduling an upcoming “Welcome to Medicare Visit” or “Annual Wellness Visit” with us. Enclosed with this letter you will find information that Medicare requires you to complete as a part of your scheduled visit. It is important that you read all the information provided as you will need to understand what services will be provided by Medicare during each type of visit.

We ask that you complete the enclosed forms **PRIOR** to arriving for your scheduled appointment.

How can you help us provide this new benefit?

- Fill out the forms. We will make every effort to provide you with the forms before you come to the office. If you do not receive any forms to complete in advance, please come to the office 30 to 45 minutes ahead of your appointment time to complete them. Our physicians’ schedules are very full and it will become difficult for everyone if the forms are not completed in advance.
- Tell us if you are in your first year of Medicare eligibility so that we can give you the proper forms and file the correct codes to Medicare.
- Be organized and ready when you see the doctor. Bring your medicines with you and make a list of concerns you have had since your last appointment.

There is no cost to you for this annual wellness exam. Your physician may treat other acute and chronic health issues apart from your wellness exam at the same appointment. Charges for these separate services will be filed to Medicare as well and may result in out-of-pocket expenses for you based on your normal benefits for illness visits.

If you have questions about any of the enclosed information or on how to complete the required forms, please contact our office at 704-302-8100.

Sincerely,

The Physicians and Staff of Mecklenburg Medical Group

Your signature below indicates that you have read and understand that you will be financially responsible for the portion of your physical not covered by your insurance.

Signature

Date

Patient History Form

DATE ____/____/____

Patient Name _____ Age _____ Date of Birth ____/____/____ MRN # _____

As part of your Medicare **Annual Wellness Visit**, please complete the following questionnaire to the best of your ability. It is an important and confidential part of your medical record.

Please list all of your Medical Providers and Suppliers involved in your care:

Please List All Current Medications and Supplements (include over-the-counter & prescription medicine):

Please list any hospitalizations or surgeries you have undergone and the year performed:

Hospitalization / Surgery	Year

Do you smoke cigarettes?
 No Yes; how many packs per day? ____

Do you drink alcohol?
 No Yes; how many drinks per day? ____

Have you used drugs for recreation?
 No Yes; what type and when?

Have you or others in your immediate family (parents, grandparents, brothers, sisters, children or grandchildren) had any of the following? (Please check all that apply.)

	Self	Family Member (list relation)		Self	Family Member (list relation)		Self	Family Member (list relation)
General:			Respiratory:			Neurologic:		
Cancer: Breast	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Nerve Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: Colon	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric:		
Head:				<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Trauma	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal:			Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>
Eyes:			GERD	<input type="checkbox"/>	<input type="checkbox"/>	Phobias	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	GI Bleed	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine:		
	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Ears, Nose, Mouth & Throat				<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary:				<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Prostate	<input type="checkbox"/>	<input type="checkbox"/>	Hematologic:		
	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:			Urinary Infection	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Immunologic:		
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal:			HIV	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Please list any other condition below:		
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
Heart arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Skin:	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Patient Signature: _____ Provider Signature: _____



Carolinah HealthCare System

Functional Abilities / Depression Questionnaire

Instructions: Patient and/or Patient's Representative complete Section A

Healthcare Team Member complete Section B

Patient name: _____

Date: _____

Section A

Functional Abilities Assessment: Please indicate Yes or No if you require assistance with any of the following activities.

Yes	No	
		Eating
		Bathing
		Dressing
		Grooming
		Going to the toilet
		Preparing meals
		Housework

Yes	No	
		Shopping
		Climbing stairs
		Communicating with others
		Moving in and out of bed or chairs
		Following a prescribed drug regimen
		Driving or accessing transportation services
		Managing finances

Please indicate Yes or No for each of the following questions about home safety.

Yes	No	
		Do you have any hearing difficulty or require hearing aid(s)?
		Are lamp, extension, and telephone cords placed out of the traffic flow?
		Are cords in good condition, out from under rugs and furniture?
		Do extension cords always carry their proper load?
		Are all small rugs and runners slip resistant?
		Are emergency numbers posted on or near telephones?
		Could you access a telephone should you experience a fall that prevents you from standing?
		Are all smoke detectors properly placed and in good working order?
		Are all small stoves and heaters placed where they cannot be knocked over and away from furnishings (furniture, curtains, rugs, etc.)?
		Is wood burning equipment installed properly?
		Do you have an emergency exit plan and alternate exit plan in case of fire?
		Are towels, curtains, and other things that might catch fire located away from the range?
		Are all extension cords and appliance cords located away from the sink or range areas?
		Are hallways, passageways between rooms and other heavy traffic areas well lit?
		Are exits and passageways kept clear?
		Are bathtubs and showers equipped with non-skid mats, abrasive strips, or surfaces that are not slippery?
		Do bathtubs and showers have at least one (preferably two) grab bars?
		Are all medicines stored in the containers that they came in and are they clearly marked?
		Is a lamp or light switch within reach of your bed?
		Are ash trays, smoking materials, or other fire sources (heaters, hot plates, teapots, etc.) located away from beds or bedding?
		Are heating pads always turned off before going to sleep?
		Is there a telephone close to your bed?
		Are stairs well lighted?
		Do the stair steps allow for secure footing?

Section B

Depression Assessment: Use PHQ-9 to evaluate the patient's risk for depression.

PHQ-9 is available on Canopy as a Power Form. Follow the link below for instructions on accessing this form.

<https://carolinahhealthcare.sharepoint.com/sites/eLink/preventive/Canopy%20Instructions%20for%20PHQ-9%200816.pdf>

Non-Canopy users may access PHQ-9 via the following hyperlink.

<https://carolinahhealthcare.sharepoint.com/sites/eLink/preventive/Patient%20Depression%20Questionnaire%200816.pdf>