Cappleman Medical Group
Checklist & Questionnaires for your Medicare Wellness Annual Visit

Today's Date:		SMOKING, ALCOHOL & CAFFEINE		
Patient Name:	DOB	Do you smoke or use any type of tobacco? Yes (Circle): Cig/Pipe/Cigar/Chew or other? How much? _____ppd/_____ How long? _____yrs	Y	N
HT: ___________ WT:___________ BMI__________ BP:_______________ P:_____________02:________		Are you a former tobacco user? Yes (Circle): Cig/Pipe/Cigar/Chew or other? How much? _____ x _____yrs QUIT: ____________	Y	N
Which best describes your health? (Circle) Excellent Very Good Good Fair Poor	Do you Exercise? What type? How often? ____________________	Do you drink alcoholic beverages? If Yes, In the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages did you have? (Circle) Occasional / Daily / 2-5 per week 6-9 per week / 10 or more per week	Y	N

Do you feel safe in your home?	YES	NO
Have you been physically abused?	YES	NO
Have you been mentally abused?	YES	NO

Do you drink caffeinated beverages? Y N
Yes (Circle) Coffee, Soda or energy drinks?
How much? ________cups/cans per day

Office Use Only:
Cognitive Status: Excellent/Diminished/Dementia/Alzheimer's/Parkinson's or other__________________
Sensory: Touch-No problems, decreased sensitivity (Hot/Cold)Numbness
Smell/Taste-No problems/some changes: ____________

ADVANCED CARE PLANNING: Does the patient have? *Indicate YES or NO to the following*:

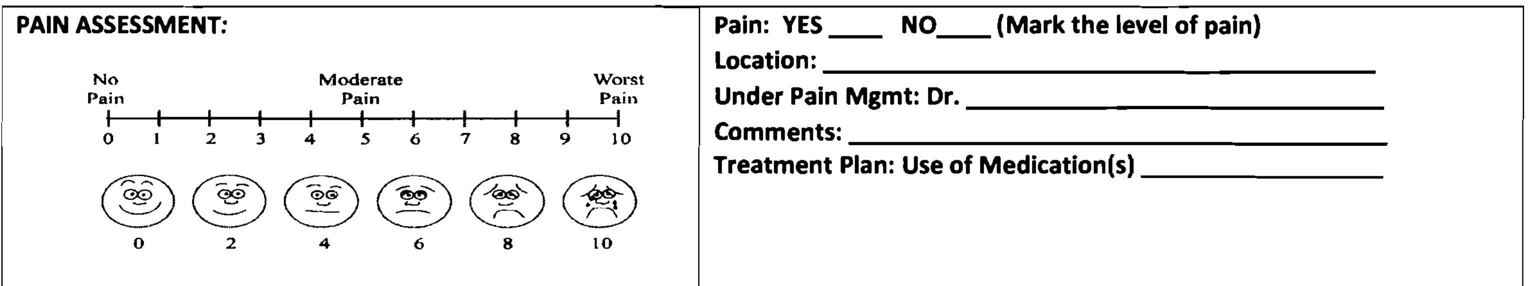
Advanced Directive? YES NO	Living Will? YES NO	Surrogate Decision Maker? YES NO

1157F-Copy/Documented in Chart	1158F- Date Discussed with Patient/Family Member Date: / /

MEDICATION REVIEW AND RECONCILIATION

1159F-Medication list placed in patient chart	1160F-Medication Reviewed with patient and documented in chart

PAIN ASSESSMENT:



Pain: YES ____ NO____ (Mark the level of pain)
Location: ______________________________
Under Pain Mgmt: Dr. ____________________________
Comments: ______________________________
Treatment Plan: Use of Medication(s) _______________

Specialists or Other Health Care Providers		
Name	**Specialists/Services**	**Phone #**

PHARMACY	**Phone #**
PHARMACY	**Phone #**

Counseled & Education Provided on: HTN-CARDIAC DIET–DASH or Low Sodium & Low Fat DIET, DM or Low Sugar DIET or Nutritional supplements		
Counseled on Alcohol Misuse		Educational literature and/or brochures provided to patient
Counseled on Smoking or Tobacco use and cessation –		Patient understands the risks involved in their lifestyle choices
Comments:		

Functional & Activities of Daily Living (ADL) QUESTIONNAIRE Do you need help with the following: (please circle) eating, bathing, toilet assistance, dressing or getting around your home?		
Can you get out of bed by yourself?	Y	N
Can you prepare your own meals?	Y	N
Do you write checks and pay your own bills?	Y	N
Can you do your own housework without help?	Y	N
Can or do you do your own shopping?	Y	N
Do you use a cane, walker, wheelchair, scooter or another person to get around?	Y	N
Do you drive or have other means of transportation outside your neighborhood?	Y	N
Are you able to keep track of appointments, family occasions and current events?	Y	N
Are you able take medicine according to directions, dosing, etc.?	Y	N
Are you still able to play games of skill that you Enjoy or work on a favorite hobby?	Y	N
Do you have any amputations or limitations?	Y	N
Are you confident that you can control and Managed most of your health problems	Y	N
Are you continent (Bowel & Bladder)?	Y	N
Do you frequently or feel the urge to Urinate	Y	N

Screening for Hearing Loss How would you evaluate your hearing (Please circle) excellent, good or poor?		
Do you have trouble following the conversation when two or more people talk at the same time	Y	N
Do you wear hearing aids or use a hearing device?	Y	N
Do you have to strain to understand conversation?	Y	N
Do you have a problem hearing over the telephone?	Y	N
Do you find yourself asking people to repeat themselves?	Y	N
Do you have trouble hearing in a noisy background?	Y	N
Do people complain that you turn the TV or radio volume up too high?	Y	N
Do you misunderstand what others are saying and respond inappropriately?	Y	N
Do you have trouble understanding the speech of women and children?	Y	N
Do people get annoyed because you misunderstand what they say?	Y	N

VISION SCREENING How would you describe your vision? (Circle) Excellent/Good or Poor		
Have you ever been diagnosed with Cataracts/Glaucom Macular Degeneration/Diabetes Retinopathy?	Y	N
Do you wear glasses or contacts?	Y	N
Have you had a recent eye exam? Dr.	Y	N

PATIENT HEALTH QUESTIONNAIRE-2 PHQ-2 Over the past 2 weeks, how often have you been Bothered by any of the following problems?	*Office Use-If Yes to the following questions, administer PHQ-9*		
	1) Little interest or pleasure in doing things?	Y	N
	2) Feeling down, depressed or hopeless?	Y	N

SCREENING FOR SAFETY & RISK OF FALLS	Y	N
Are you afraid of falling?	Y	N
Have you fallen 2 or more times in the past year? Do you have trouble getting out of a chair?	Y	N
Do your feet feel "Heavy when you walk or have numbness?" (Please circle)	Y	N
Do you ever feel light-headed upon rising from a seated position?	Y	N
When walking, can you start and stop without difficulty?	Y	N
Do you ever lose your balance with movements such as bending over, turning around, etc?	Y	N
Do you always wear a seat belt when you are in a car?	Y	N
Do you have furniture with sharp corners, or a rickety chair that could cause injury?	Y	N

Do you have pets that stay indoors?	Y	N
Do you have night lights in your house?	Y	N
Do you keep medicines in a safe place and have their directions clearly labeled?	Y	N
Do you keep knives and other sharp objects put away in a safe place?	Y	N
Do you have throw rugs on hardwood floors in your house?	Y	N
Does your house have smoke alarms and carbon monoxide detectors in good working order?	Y	N
Does your bathtub contain a safety measure such as a rubber mat or strips?	Y	N
Do you have loose or frayed cords or overloaded electrical sockets in your home?	Y	N
Do you keep poisons, chemicals or other toxic substances put away in a safe place?	Y	N

Patient Name (Printed)	Patient Signature:	DOB:	Date:
Physician Name (Printed)	Physician Signature:	Credentials	Date:

Pre-planning for end of life decisions

What is a medical power of attorney?

A medical power of attorney is one type of the legal forms called advance directives. It lets you decide who you want to make treatment decisions for you if you cannot speak or decide for yourself. The person you choose is called your health care agent.

Another type of advance directive is a living will. It lets you write down what kinds of treatment or life support you want or do not want.

What should you think about when choosing a health care agent?

Choose your health care agent carefully. This person may or may not be a family member.

Talk to the person before you make your final decision. Make sure he or she is comfortable with this responsibility.

It's a good idea to choose someone who:

- Is at least 18 years old.
- Knows you well and understands what makes life meaningful for you.
- Understands your religious and moral values.
- Will do what you want, not what he or she wants.
- Will be able to make difficult choices at a stressful time.
- Will be able to refuse or stop treatment, if that is what you would want, even if you could die.
- Will be firm and confident with health professionals if needed.
- Will ask questions to get necessary information.
- Lives near you or agrees to travel to you if needed.

Your family may help you make medical decisions while you can still be part of that process. But it is important to choose one person to be your health care agent in case you are not able to make decisions for yourself.

If you don't fill out the legal form and name a health care agent, the decisions your family can make may be limited.

Who will make decisions for you if you do not have a health care agent?

If you don't have a health care agent or a living will, your family members may disagree about your medical care. And then some medical professionals who may not know you as well might have to make decisions for you. In some cases, a judge makes the decisions.

When you name a health care agent, it is very clear who has the power to make health decisions for you.

How do you name a health care agent?

You name your health care agent on a legal form. It is usually called a medical power of attorney. Ask your hospital, state bar association, or office on aging where to find these forms.

You must sign the form to make it legal. Some states require you to get the form notarized. This means that a person called a notary public watches you sign the form and then he or she signs the form. Some states also require that two or more witnesses sign the form.

Be sure to tell your family members and doctors who your health care agent is.

Keep your forms in a safe place. But make sure that your loved ones know where the forms are. This could be in your desk where you keep other important papers.

DESIGNATION OF HEALTH CARE SURROGATE

Name: ____
(Last) *(First)* *(Middle Initial)*

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: ____

Address: ____

City: ______________________ State__________ Zip Code: ________

Phone: ____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: _______

Phone: ____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:

Name: ____

Address: ____

Name: ____

Address: ____

Signed: ____________________________________ Date: __________

Witness 1:

Signed: ____________________________________ Date: __________

Address: ____

Witness 2:

Signed: ____________________________________ Date: __________

Address: ____

Would you choose life-sustaining procedures if: (e.g. assistance with respiration, mechanical means to maintain blood pressure and heart rate, tube feeding):

Choose one of the following for each question:

• If I were gravely impaired by Alzheimer's Disease?	Use	Do Not Use	Only if my doctor believes it could help
• If I am in a coma from which I am not expected to wake up?	Use	Do Not Use	Only if my doctor believes it could help
• If my brain's thinking functions were severely damaged?	Use	Do Not Use	Only if my doctor believes it could help
• If I were near death with a terminal illness?	Use	Do Not Use	Only if my doctor believes it could help
• If I could recover sufficiently to be comfortable and active?	Use	Do Not Use	Only if my doctor believes it could help

Below list any other conditions which you believe that burdens of life support treatment are too much and not worth the benefits and therefore do not wish to have life-support treatment:

Name: ______________________________ Date: ______________________________

Signature: ______________________________ Witness: ______________________________

Home Safety Checklist

____Remove raised doorway thresholds, throw rugs, and clutter. Repair loose carpet or raised areas in the floor.

____ Move furniture and electrical cords to keep them out of walking paths.

____Use nonskid floor wax, and wipe up spills right away, especially on ceramic tile floors.

____If you use a walker or cane, put rubber tips on it. If you use crutches, clean the bottoms of them regularly with an abrasive pad, such as steel wool.

____Keep your house well lit, especially stairways, porches, and outside walkways. Use night-lights in areas such as hallways and bathrooms. Add extra light switches or use remote switches (such as switches that go on or off when you clap your hands) to make it easier to turn lights on if you have to get up during the night.

____ Install sturdy handrails on stairways. Put grab bars near your shower, bathtub, and toilet.

____Store household items on low shelves so that you do not have to climb or reach high. Or use a reaching device that you can get at a medical supply store. If you have to climb for something, use a step stool with handrails, or ask someone to get it for you.

____Keep a cordless phone and a flashlight with new batteries by your bed. If possible, put a phone in each of the main rooms of your house, or carry a cell phone in case you fall and cannot reach a phone. Or you can wear a device around your neck or wrist. You push a button that sends a signal for help.

____Wear low-heeled shoes that fit well and give your feet good support. Use footwear with nonskid soles. Check the heels and soles of your shoes for wear. Repair or replace worn heels or soles.

____Do not wear socks without shoes on wood floors.

____Walk on the grass when the sidewalks are slippery. If you live in an area that gets snow and ice in the winter, sprinkle salt on slippery steps and sidewalks.