

Piedmont Internal Medicine

Medicare Preventive Exam

Welcome to your annual Medicare Preventive Exam! This exam is intended to help promote your health and identify major risks for disease. Medicare covers this exam once per year. This Medicare benefit has 3 different names based on when it occurs, as follows:

- “Initial Preventive Physical Exam”** (IPPE)
 - also called the “Welcome to Medicare Exam”
 - available anytime within the first 12 months of joining Medicare

- “First Annual Wellness Visit”** (FAWV)
 - available anytime after the first 12 months of joining Medicare

- “Subsequent Annual Wellness Visit”** (SAWV)
 - available annually after the First Annual Wellness Visit above

Your preventive exam will assess the following:

- your medical and surgical history
- your current medications
- your relevant family history
- your use of any alcohol, tobacco, or illicit drugs
- your current diet and physical activity
- any other providers / suppliers involved in your care
- any depression, cognitive impairment, or safety concerns
- an exam of your height, weight, body mass index, BP, & vision, along with any other areas of concern based on the above assessments
- any “end-of-life” planning concerns

The exam concludes with the following:

- development of a list of any identified preventive health concerns (a “problem list”)
- education, counseling, and referrals based on any such concerns
- a personalized written “screening schedule” detailing any recommended screening/preventive services that are covered by Medicare
- recommendations for end-of-life planning, if needed and desired
- other preventive services as may be recommended by your doctor

PLEASE NOTE: Per Medicare, this annual Medicare Preventive Exam is intended to be a “wellness” exam, limited to health promotion and disease prevention. To the extent that you and your doctor spend any time during your preventive exam addressing non-preventive issues such as illnesses, diseases, and/or injuries that you may have, Medicare has directed us to code and bill for such services separately and in addition to the preventive exam. We mention this in advance of your exam so that you are aware that you may incur charges for this visit, depending on the extent of the exam and any copays and/or deductibles you may be responsible for through your Medicare coverage.

To get started, please complete the following 3 pages of questions,
to the best of your ability,
IN ADVANCE of your visit with the doctor.



Piedmont Internal Medicine
Medicare Preventive Questionnaire

- IPPE
- FAWV
- SAWV

Your Name (Please Print)

Date of Birth

Exam Date

- I am a new patient at the practice (if so, skip to the next section on this page)
- I am an established patient at the practice (if so, start with this section)

Since your last visit here:

- have you been diagnosed with any new medical conditions? ___ Yes ___ No
If Yes, details: _____

- have you undergone any recent surgical procedures? ___ Yes ___ No
If Yes, details: _____

- have you had any medication, vitamin, or supplement changes? ___ Yes ___ No
If Yes, details: _____

- have any close family members developed any serious illnesses? ___ Yes ___ No
If Yes, details: _____

- have you changed your use / nonuse of tobacco or alcohol? ___ Yes ___ No
If Yes, details: _____

Please Describe your Current Diet (check all that apply):

- ___ Well-Balanced, Controlled Portions ___ Unbalanced ___ Excessive Portions
- ___ Low Salt ___ Low Fat ___ Low Carbs ___ Restricted Calories (_____ cal/ day)
- ___ Other: _____

Please Describe your Current Activity Level:

- ___ Minimal ___ Active, but No Exercise ___ Some Exercise ___ Regular Exercise

Please List Any Other Doctors / Suppliers Regularly Involved with Your Care:

Name _____	Specialty _____
Name _____	Specialty _____
Name _____	Specialty _____
Name _____	Specialty _____
Name _____	Specialty _____

End-of-Life Planning

All physicians at Piedmont Internal Medicine honor our patients' end-of-life wishes, including: advance directives, living wills, and, resuscitation desires . . .

Do you wish to discuss any end-of life issues during this exam? ___ Yes ___ No

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Depression Screening

Do you have a diagnosis of depression? ___ Yes ___ No
Did you used to have depression in the past, but not now? ___ Yes ___ No
Do you have any parents or siblings with depression? ___ Yes ___ No
Have you felt significantly depressed lately? ___ Yes ___ No
Do you ever have suicidal feelings? ___ Yes ___ No

Please select the best answer for how you have felt over the past week:

Are you dissatisfied with your life the way it is now? ___ Yes ___ No
Have you dropped many of your hobbies / interests? ___ Yes ___ No
Do you feel that your life is pretty empty right now? ___ Yes ___ No
Do you often get bored? ___ Yes ___ No
Are you in bad spirits most of the time? ___ Yes ___ No
Do you fear something bad is going to happen to you? ___ Yes ___ No
Do you feel sad most of the time? ___ Yes ___ No
Do you often feel helpless? ___ Yes ___ No
Do you prefer to stay at home rather than going out? ___ Yes ___ No
Are you having significant trouble with your memory? ___ Yes ___ No
Do you feel that it is not all that great to be alive now? ___ Yes ___ No
Do you feel fairly worthless the way you are now? ___ Yes ___ No
Do you feel overly tired and without much energy? ___ Yes ___ No
Do you feel that your situation is fairly hopeless? ___ Yes ___ No
Do you think most people are better off than you are? ___ Yes ___ No

For Staff Use Only:	
Total Score	_____
<u>Conclusion:</u>	(circle)
0-4	Low Risk
5-9	Medium Risk
9+	High Risk

*Geriatric Depression Scale

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Cognition Screening

- Do you feel you have any significant memory problems? ___Yes ___No
- Have you forgotten what you had for dinner yesterday? ___Yes ___No
- Do you have to keep lists so you don't forget things? ___Yes ___No
- Do you frequently lose things at home or at work? ___Yes ___No
- Have you ever gotten lost while driving? ___Yes ___No
- Have you ever forgotten why you are at a store? ___Yes ___No
- Have you had trouble balancing your checkbook lately? ___Yes ___No
- Do people often accuse you of repeating yourself? ___Yes ___No

Safety Screening

- Do you feel you have any significant safety concerns? ___Yes ___No
- Do you have any trouble seeing, hearing, or speaking? ___Yes ___No
- Do you have any trouble bathing, dressing, or eating? ___Yes ___No
- Do you feel unstable or unsteady when standing? ___Yes ___No
- Do you have any trouble using stairs, if you have them? ___Yes ___No
- Have you fallen or almost fallen in the last 60 days? ___Yes ___No
- Do you know of any fire hazards in your home? ___Yes ___No
- Would you have any trouble getting 911 help if needed? ___Yes ___No

If you answered "Yes" to any questions on this page, please provide details below:

Please present these COMPLETED forms to the nurse at your appointment! Thank you!