Spanish Hills Medical Group, Inc.

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To our valued Medicare patients:

As of January, 2011 Medicare allows a yearly ***free*** Annual Wellness Visit. The Annual Wellness Visit is different from the traditional routine physical because it screens for risks specific to the senior population (such as fall prevention, for instance). Your annual wellness visit is the ***only*** preventative visit that Medicare will reimburse. We ask, therefore, that this visit be limited to developing your personalized prevention plan. Your physician will provide you with a written list of tests and interventions that he recommends specifically for you. If you do have more urgent concerns (such as chest pain, problems urinating, shoulder pain, etc.) we request that you schedule a separate appointment to address this. Copay's and deductibles will apply for any care that is ***not*** a part of your annual wellness visit.

Our records indicate that you **do not have an Advanced Directive or Living Will on file with our office**. If you already have one completed, please bring this with you to your visit. If you do not have one, we have enclosed a copy of one for you (Five Wishes). Please review with your chosen proxy or representative. This would be the person you choose to make your health care choices if you are no longer able to do so. If you have questions regarding this issue you should discuss this with your physician at the time of your visit. If you choose to complete the Five Wishes we will provide you with an original at any time.

To make your annual wellness visit as helpful as possible, we ask that you complete the attached Annual Wellness visit forms. Please be thorough and complete. ***Please bring these forms with you along with your medications, vitamins and supplements to your visit.***

We look forward to seeing you for your annual wellness visit on

_____at_____AM/PM

If you have any questions, please do not hesitate to call 805 981-8300.

Sincerely,

Spanish Hills Medical Group

Spanish Hills Medical Group Health Risk Assessment

Patient Name: _____
Date of birth: _____
Date: _____

Physical Activity
In the past 7 days, how many days did you exercise?
_____days

On days when you exercised, for how long did you exercise (in minutes)?
_____minutes per day
_____does not apply

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)
____I am currently not exercising

Hearing
Have you noticed any hearing difficulties?
- ☐ Yes
- ☐ No

Tobacco Use
In the last 30 days, have you used tobacco?
Smoked? Yes/no (circle one please)

Used a smokeless tobacco product:
- ☐ Yes
- ☐ No

If Yes to either,
Would you be interested in quitting tobacco use within the next month?
- ☐ Yes
- ☐ No

Patient Name: _____
Date of birth: _____

Alcohol Use

In the past 7 days, on how many days did you drink alcohol?
_____ Days

On days when you drank alcohol, how often did you have _____?
(5 or more for men, 4 or more for women and those men and women 65 years old or ever) Alcoholic drinks on one occasion?

- ☐ Never
- ☐ Once during the week
- ☐ 2-3 times during the week
- ☐ More than 3 times during the week

Do you ever drive after drinking, or ride with a driver who has been drinking?

- ☐ Yes
- ☐ No

Nutrition

In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)

_____ Servings per day

In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day?
(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)
_____ Servings per day

In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, donuts, creamy salad dressings, and foods made with whole milk, cream, cheese or mayonnaise.)
_____ Servings per day

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?

_____Sugar sweetened beverages consumed per day

Seat Belt Use

Do you always fasten your seat belt when you are in a car?

- ☐ Yes
- ☐ No

Patient Name: _____
Date of birth: _____

Depression:
In the past 2 weeks, how often have you felt down, Depressed or hopeless?

- ☐ Almost all the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost never

In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

- ☐ Almost all of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost Never

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?

- ☐ Yes
- ☐ No

If Depression screening positive (MA please initiate PHQ-9)*

Anxiety
In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

- ☐ Almost all of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost never

In the past 2 weeks, how often were you not able to stop worrying or control you're worrying?

- ☐ Almost all of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost never

High Stress
How often is stress problem for you in handling such things as?
-Your health? - Your Finances? -Your family or social relationships? -your work?

- ☐ Never or rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Social/Emotional Support
How often do you get the social and emotional support you need:

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

Patient Name: _____
Date of birth: _____

Pain
In the past 7 days, how much pain have you felt?
- ☐ None
- ☐ Some
- ☐ A lot

General Health
In general, would you say your health is?
- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

How would you describe the condition of your mouth and teeth-including false teeth or dentures?
- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

Activities of Daily Living
In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using toilet?
- ☐ Yes
- ☐ No

Instrumental Activities of Daily Living
In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, baking, shopping, using telephone, food preparation, transportation, or taking your own medications?
- ☐ Yes
- ☐ No

Sleep
Each night, how many hours of sleep do you usually get?
_____ Hours

Do you snore or has anyone told you that you snore?
- ☐ Yes
- ☐ No

In the past 7 days, how often have you felt sleepy during the daytime?
- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Patient Name: _____

Date of birth: _____

Medical History:

Please list the name of all your doctors and Suppliers:

(Example: Liberty Medical-Diabetic Supplies, Dr. Peters- Ophthalmologist)

Name:	Specialty:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list all your medications including supplements and vitamins:

Name of medication/supplement/vitamin:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Drug allergies:

_____

_____

Have any of your close relatives (parents, siblings, or children) had any health changes?
If yes please list:

_____

_____

Please provide the date of your last:
Vision-Glaucoma screening:_____
Mammogram/women:_____
Pap Smear/women:_____
Bone Density Measurement:_____
Cardiovascular screening (lipid, cholesterol, lipoprotein, triglycerides testing):_____
Diabetes Screening:_____
Colonoscopy or other colorectal cancer screening:_____
HIV screening:_____
Pneumonia vaccine:_____
Influenza vaccine:_____
Hepatitis B vaccine:_____
Dental Exam:_____
PSA testing/men:_____
Abdominal Aortic Aneurysm Ultrasound screening/men: _____

Reviewed by: MA: _____ **PCP:** _____

Fall Prevention Balance and Dizziness Survey

Patient Name: _____ **Age:** _____ **Date:** _____

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

Please read each question and check the box that most describes your answer.	Yes or Often	Some-times	No or Never
1. Have you fallen more than once in the past year without an obvious cause?			
2. Do you ever fall or feel like you are about to fall for no apparent reason?			
3. Do you fear falling or are you worried about losing your balance?			
4. Have you experienced dizziness, vertigo, or serious imbalance in the past six months?			
5. Do you feel unsteady when you are walking or climbing stairs?			
6. Do you feel dizzy while sitting down or rising from a seated or lying position?			
7. Does walking down the aisle of a supermarket or stopping next to moving traffic make you dizzy?			
8. Does moving your head quickly make you dizzy or cause you to feel nauseous?			
9. Are you dizzy or unsteady when you first get up in the morning?			
10. Have you continued to experience dizziness after an injury or accident?			
11. Do you use or have you ever been advised to use a walker, cane, or any other form of assistance for your mobility?			
12. Have you had a recent loss of, or decrease in, your vision or hearing?			
13. Does dizziness or imbalance interfere with your job or your household responsibilities?			
14. Has your balance problem caused problems in your social life?			
15. Do you ever lose your balance or feel dizzy or unsteady?			
16. Do you steady yourself by holding onto furniture when walking at home?			

Please fill out the top with your name and date, sign the survey at the bottom and provide this to your physician during your visit.

_____ Patient Signature

_____ Phone

SPANISH HILLS MEDICAL GROUP

Peripheral Arterial Disease (PAD) Questionnaire

Date/Fecha:	
Name/Nombre:	
DOB/Fecha de Nacimiento:	
Sex/Género:	

Answers to the following questions will help determine if you are at risk for PAD and if a vascular examination can help better assess your vascular health status.

Sus respuestas a las siguientes preguntas determinaran si estas a riesgo de PAD y si un examen vascular le podrá asesar mejor su salud vascular.

1. Do you experience any pain in your legs or feet while at rest? ¿Siente dolor en sus piernas o pies cuando estas descansando?	□Yes/Si □No/No
2. Do you have uncomfortable aching, fatigue, tingling, cramping or pain in your feet, calves, buttocks, hip or thigh during walking/exercise? Tiene dolor, fatiga, hormigueo, calambres o dolor en los pies, pantorrillas, glúteos, cadera o muslo al caminar / hacer ejercicio?	□Yes/Si □No/No
If yes to Question 2, does the pain go away when you stop walking/exercising? Si contestaste si a la segunda pregunta, el dolor desaparece cuando deja de caminar / hacer ejercicio?	□Yes/Si □No/No
3. Do your feet get pale, discolored or bluish at any time during the day? ¿Tus pies se ponen pálidos, descoloridos o azulados en cualquier momento durante el día?	□Yes/Si □No/No
4. Do you have an infection, skin wound or ulcer on your leg or foot that is slow to heal over the past 8-12 weeks?	□Yes/Si □No/No

¿Tiene una infección, una herida en la piel o una úlcera en su pierna o pie que tarda en sanar en las últimas 8-12 semanas?	
5. Do you have high cholesterol or other blood lipid (fat) problems or require cholesterol medication? ¿Tiene problemas de colesterol alto u otros problemas de lípidos o necesita medicamentos para el colesterol?	□Yes/Si □No/No
6. Do you have high blood pressure or take medication to reduce blood pressure? ¿Tiene presión arterial alta o toma medicamentos para reducir la presión arterial?	□Yes/Si □No/No
7. Do you have diabetes? ¿Tienes diabetes?	□Yes/Si □No/No
8. Do you have a history of chronic kidney disease? ¿Tiene antecedentes de enfermedad renal crónica?	□Yes/Si □No/No
9. Do you currently or have you ever smoked? ¿Actualmente o alguna vez has fumado?	□Yes/Si □No/No
10. Do you have a history of stroke or mini stroke (TIA)? ¿As tenido accidente cerebrovascular o mini accidente cerebrovascular?	□Yes/Si □No/No
11. Do you have a history of heart disease (heart attack, MI)? ¿Tiene historia de enfermedad cardíaca (ataque cardíaco)?	□Yes/Si □No/No
12. Do you have a history of carotid stenosis, AAA (abdominal aortic aneurysm), atheroembolism, thoracic aneurysm and/or stent placement? Tiene antecedentes de estenosis carotídea, AAA (aneurisma aórtico abdominal), ateroembolismo, aneurisma torácico y / o colocación de stent?	□Yes/Si □No/No