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Dear _____

We are writing to remind you that your annual complete physical exam is scheduled for _____ at _____. Please bring all your medications with you for this visit. **Please do not eat the morning of your appointment unless there is a medical reason that prevents you from fasting.** (You may have water, black coffee and/or tea the morning of your appointment).

You are responsible for knowing whether or not your insurance provides coverage for preventative or diagnostic physicals and you must notify your physician at the start of your physical.

Medicare patients: The Annual Medicare Wellness Visit is not the same as what many people often refer to as their yearly physical exam. The Wellness Visit does not include a hands-on exam or any testing that your Doctor may recommend, or medication. At your yearly physical exam, you can discuss with your Doctor when to schedule your Annual Wellness visit.

We are including a registration form we would like you to fill out and bring with you.

Thank you for your participation and we look forward to addressing your health care needs in the future.

Sincerely,

Troy Internal Medicine

We kindly ask that you arrive fifteen minutes prior to your appointment. Please bring your identification and insurance card(s) with you.

If you have NOT YET confirmed your appointment, please call and confirm at (248) 267-5000.

Thank You.

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Hearing Handicap Inventory for the Elderly Screening Version (HHIE-S)

Instructions: Please check "yes," "no," or "sometimes" in response to each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

	Item	Yes (4 pts)	Sometimes (2 pts)	No (0 pts)
E	Does a hearing problem cause you to feel embarrassed when meeting new people?	_____	_____	_____
E	Does a hearing problem cause you to feel frustrated when talking to members of your family?	_____	_____	_____
S	Do you have difficulty hearing when someone speaks in a whisper?	_____	_____	_____
E	Do you feel handicapped by a hearing problem?	_____	_____	_____
S	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	_____	_____	_____
S	Does a hearing problem cause you to attend religious services less often than you would like?	_____	_____	_____
E	Does a hearing problem cause you to have arguments with family members?	_____	_____	_____
S	Does a hearing problem cause you difficulty when listening to TV or radio?	_____	_____	_____
E	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	_____	_____	_____
S	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	_____	_____	_____
	TOTAL SCORE = _____ (sum of the points assigned to each of the items)			

E = Emotional; S = Social

Interpretation of score:

0-8 suggest no hearing handicap
10-24 suggest mild-moderate hearing handicap
26-40 suggest significant hearing handicap

0 to 8 = 13% probability of hearing impairment (no handicap/no referral)
10 to 24 = 50% probability of hearing impairment (mild-moderate handicap/refer)
26 to 40 = 84% probability of hearing impairment (severe handicap/refer)

Refer for additional hearing evaluation if score is $\geq$ 10 points

The Hartford Institute for Geriatric Nursing recognizes Kathleen Demers as the original author of this issue.

Name: _____ Date of Birth: _____ Date: _____

A Checklist for Your Medicare Wellness Annual Visit

Please complete this checklist before seeing the doctor or nurse. Your answers will help receive the best health possible. (Circle THE APPROPRIATE RESPONSE and/or the answer following the question)

YES/NO Do you eat a balanced daily diet?

YES/NO Do you eat 3 meals a day?

In the last 7 days, how often did you eat 3 or more servings of fruits or vegetables?

Do you take any dietary supplements or vitamins? If so, what? _____

Each night, how many hours of sleep to you usually get? 1 2 3 4 5 6 7 8 9>

YES/NO Do you snore or has anyone else told you snore?

YES/NO In the past 7 days, have you felt sleepy during the daytime?

How many days a week do you exercise on average? 1 2 3 4 5 6 7

What type of exercise? _____

On days that you exercise, how long did you exercise for? _____

YES/NO Because of a health or memory problem, do you have any difficulty with bathing or showering?

YES/NO Because of a health of memory problem, do you have any difficulty with toileting – such as transferring yourself to the toilet, cleaning yourself or having incontinence of stool or urine?

YES/NO Because of a health or memory problem, do you have difficulty grooming yourself (brushing hair, brushing teeth etc)?

YES/NO Any trouble with walking without assistance?

YES/NO Any trouble getting out of: Bed, Chair, Car, _____? (Circle appropriate answers)

YES/NO Are you able to do housework with limited or no assistance?

YES/NO Are you able to grocery shop with limited or no assistance?

YES/NO Are you able to manage medications with limited or no assistance?

YES/NO Are you able to manage money (such as paying your bills, keeping track of expenses) with limited or no assistance?

YES/NO Are you able to prepare meals with limited or no assistance?

YES/NO Are you able to use the phone with limited or no assistance?

YES/NO Any fall in the last year?

YES/NO Any fall within the last 3 months?

YES/NO Are you afraid of falling?

YES/NO Any dizziness/vertigo?

YES/NO Any history of frequent falls while walking?

YES/NO Any use of: Canes, Walker, Wheelchair, Crutches. (Circle device)

YES/NO Are emergency numbers kept by the phone and regularly updated?

YES/NO Are working smoke alarms(s) and CO detector(s) installed in your home?

YES/NO Are working fire extinguishers(s) available for use?

YES/NO Are doorways, halls, and stairs free of clutter?

YES/NO Do all stairs have a railing or banister?

YES/NO Do you use a seatbelt in a car?

YES/NO Are non-slip mats in all bathtubs and showers?

YES/NO Are all electrical cords in working order, easily seen, and not run under rugs/carpets or wrapped around nails?

YES/NO Are sidewalks and all outdoor steps clear of tools, toys and other articles?

YES/NO During the past year, have you experienced changes in thinking, remembering, or decision making? For example, have you had more difficulty remembering people, places, or things? Have you had more difficulty making decisions?

YES/NO Do you or any of your friends or family members have any concerns about your memory?

YES/NO Does any family member have history of: alcoholism, cancer, high cholesterol, seizures, anemia, sickle cell, diabetes, hypertension, stroke , heart disease, obesity, thyroid disease, bleeding disorders, liver disease, kidney disease, myocardial infarction, etc? _____

YES/NO Have any of your close relatives had any health changes? _____

_____

YES/NO Do you see a Dentist yearly

POOR/FAIR/GOOD/EXCELLENT: How would you describe your condition of your teeth – including false teeth and/or dentures.

YES/NO Are there any preventative test you had done recently outside our office? (Labs, xrays,

Mammograms ...) _____

YES/NO Have you had any recent immunizations outside our office? _____

YES/NO Do you have a living will or advance directive? (If you have one, please bring a copy of it with you)

Do you live with someone, if so, who? _____

What is your living situation today? _____
(Home, apartment, assisted living, nursing home, homeless, shelter ...)

YES/NO Think about the place you live. Do you have problems with any of the following? If so, which? (bugs, mice, mold, lead paint, lack of heat, oven not working, smoke detectors not working,

water leaks ...) _____

OFTEN, SOMETIMES, NEVER: Within the last 12 months, have you worried that your food would run out before you got to buy more.

OFTEN, SOMETIMES, NEVER: Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

YES/NO In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things done for daily living?

YES/NO In the past 12 months has the electric, gas, oil or water company threatened to shut off services in your home? If yes, do you have any services currently shut off? If so, what? _____

**Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.

NEVER/RARELY/SOMETIMES/FAIRLY OFTEN/OFTEN: How often does anyone, including family and friends, physically hurt you?

NEVER/RARELY/SOMETIMES/FAIRLY OFTEN/OFTEN: How often does anyone, including family and friends, insult or talk down to you ?

NEVER/RARELY/SOMETIMES/FAIRLY OFTEN/OFTEN: How often does anyone, including family and friends, threaten to harm you ?

YES/NO Are you a smoker?

YES/NO If you are a smoker, would you be interested in quitting smoking within the next month?

NEVER/ONCE OR TWICE/DAILY/ALMOST DAILY: In the last 7 days, how often did you have four or more alcoholic drinks at one time?

NEVER/ONCE OR TWICE/DAILY/ALMOST DAILY: How many times in the past year have you used drugs for non-medical reasons?

NEVER/ONCE OR TWICE/DAILY/ALMOST DAILY: How many times in the past year have you used illegal drugs?

_____

Name

For Office Use Only

CLOCK DRAW

1:55

THREE WORD RECALL

_____**Performed**