FREDERICKSBURG FAMILY CLINIC, PA
d/b/a/ CORNERSTONE CLINIC

Karen G. Cornett, M.D.
Suzanne E. Ellison, M.D.
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John P. Ramsay, M.D.
Nancy M. Rickerhauser, M.D.
Kristi A. Stafford, M.D.
Erika Benfield, NP

SCREENING QUESTIONNAIRES FOR PATIENT OVER 65

A WORD TO OUR PATIENTS ABOUT MEDICARE AND WELLNESS CARE

Dear Patient,

We want you to receive wellness care-health care that may lower your risk of illness or injury. Medicare pays for some wellness care, but it does not pay for all the wellness care you might need. We want you to know about your Medicare benefits and how we can help you get the most from them.

The term "physical" is often used to describe wellness care. But Medicare does not pay for a traditional, head-to-toe physical. Medicare does pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:

- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- Recommendations for other wellness services and healthy lifestyle changes.

Before your appointment, our staff will ask you to complete the Screening Questionnaires that begins on page 2. Your provider will evaluate your answers and talk with you about any findings that may require further evaluation. These questionnaires are a required component of performing and billing the wellness visit. If you need help or have questions about any of these screenings, please talk to your provider.

A wellness visit does not deal with new or existing health problems. A separate charge may apply to these services, whether provided on the same date or a different date than the wellness visit.

We hope to help you get the most from your Medicare wellness benefits.

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Patient Name:______________________________________ Date______________
DOB______________

Mental Health Questionnaire - Choose the best answer for how you have felt over the past week:

1.	Are you basically satisfied with your life?	Yes	No
2.	Have you dropped many of your activities and interests?	Yes	No
3.	Do you feel that your life is empty?	Yes	No
4.	Do you often get bored?	Yes	No
5.	Do you feel happy most of the time?	Yes	No
6.	Are you afraid that something bad is going to happen to you?	Yes	No
7.	Do you often feel helpless?	Yes	No
8.	Do you prefer to stay home, rather than go out & do new things?	Yes	No
9.	Do you think it is wonderful to be alive now?	Yes	No
10.	Do you feel full of energy?	Yes	No
11.	Do you feel that your situation is hopeless?	Yes	No
12.	Do you frequently feel like crying?	Yes	No
13.	Do you think that most people are better off than you are?	Yes	No
14.	Do you prefer to avoid social gatherings?	Yes	No
15.	Are you hopeful about the future?	Yes	No

❑ Physician Assessment: No further evaluation needed.

❑ Referral:____

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Nutritional Health Questionnaire - Please circle Yes or No

1.	I eat fewer than two meals a day.	Yes	No
2.	I eat few fruits, vegetables, or milk products?	Yes	No
3.	I have a tooth or mouth problem that makes it hard for me to eat.	Yes	No
4.	I don't always have enough money to buy the food I need.	Yes	No
5.	I eat alone most of the time.	Yes	No
6.	I take three or more different prescription or over-the-counter medications each day.	Yes	No
7.	Without trying, I have lost or gained 10 lb. in the past six months.	Yes	No
8.	I am not always physically able to shop, cook, or feed myself.	Yes	No
9.	I have three or more drinks of beer, liquor or wine almost every day.	Yes	No

❑ Physician Assessment: No further evaluation needed.

❑ Referral:_______________________________________

Daily Living Questionnaire – Please circle Yes or No

1.	Can you use the telephone?	Yes	No
2.	Do you drive or have other means of transportation for traveling outside your neighborhood?	Yes	No
3.	Can you do your own shopping?	Yes	No
4.	Can you prepare your own meals?	Yes	No
5.	Can you do your own housework, lawn work or handyman work?	Yes	No
6.	Can you do your own laundry?	Yes	No
7.	Can you dress yourself?	Yes	No
8.	Are you able to take medicine according to directions, dosing, etc.?	Yes	No
9.	Can you manage your own money, write checks, pay bills?	Yes	No
10.	Are you able to keep track of appointments and family occasions?	Yes	No

❑ Physician Assessment: No further evaluation needed.

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Hearing Questionnaire – Please circle Yes or No

1.	Do you have a problem hearing on the telephone.	Yes	No
2.	Do you have difficulty hearing when someone speaks in a whisper?	Yes	No
3.	Do people complain that you turn the TV/radio volume up to high?	Yes	No
4.	Do you have to strain to understand conversations?	Yes	No
5.	Do you find yourself asking people to repeat themselves?	Yes	No
6.	Do you misunderstand what people are saying and respond inappropriately?	Yes	No
7.	Do you have trouble understanding the speech of women/children?	Yes	No
8.	Do people get annoyed because you misunderstand what they say?	Yes	No
9.	Do people you talk to seem to mumble, or not speak clearly?	Yes	No

❑ Physician Assessment: No further evaluation needed.

❑ Referral:_________________________________

Risk of Falling Questionnaire – Please circle Yes or No

1.	Do you notice numbness in your feet?	Yes	No
2.	Do your steps feel “heavy” when you walk?	Yes	No
3.	Do you ever feel light-headed upon rising from a seated position?	Yes	No
4.	When walking, can you start and stop without difficulty?	Yes	No
5.	Do you have trouble getting out of a chair?	Yes	No
6.	Do you have any kind of difficulty when walking?	Yes	No
7.	Do you ever lose your balance with movements such as bending over, turning around, etc.?	Yes	No
8.	Have you ever fallen in the past?	Yes	No

❑ Physician Assessment: No further evaluation needed.

❑ Get Up and Go Test Performed

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Home Safety Questionnaire - Please circle Yes or No

1.	Do you have throw rugs on hardwood floors in your house?	Yes	No
2.	Do you have pets that stay indoors?	Yes	No
3.	Does your house have smoke alarms and carbon monoxide detectors in good working order?	Yes	No
4.	Do you have night lights in your house?	Yes	No
5.	Does your bathtub contain a safety measure such as a rubber mate or strips?	Yes	No
6.	Is the area in front of your bathtub either carpeted or protected by a bath mat with rubber backing?	Yes	No
7.	Do you keep medicines in a safe place and have their directions clearly labeled?	Yes	No
8.	Do you keep knives and other sharp objects put away in a safe place?	Yes	No
9.	Do you keep poisons, chemicals or other toxic substances put away in a safe place?	Yes	No
10.	Do you have furniture, such as a coffee table with sharp corners, or a rickety chair, that could cause injury?	Yes	No

End of Life Questionnaire - Please circle Yes or No

1.	Do you have a will?	Yes	No
2.	Do you have a Power of Attorney?	Yes	No
3.	Do you have an Advanced Directive?	Yes	No

❑ Physician Assessment: No further evaluation needed.

❑ Referral:____

Physician's Signature____________________________________

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SCREENING AND IMMUNIZATION SCHEDULE

MALE PATIENT OVER 65

SCREENING	FREQUENCY
Cardio Disease Screen (Lipid Panel to include Cholesterol, HDL Cholesterol, Triglycerides)	Every 5 years
Colonoscopy Screen	Every 10 years
Depression Screen	Annually (12 months)
PSA	Annually (12 months)
IMMUNIZATIONS	**FREQUENCY**
Influenza (Flu)	Once Per Flu Season
Pneumococcal-13 valent Pneumococcal-23 valent	Once Once, one year after receiving Pneumococcal-13 valent
Tetanus/Diptheria	Every 10 Years

FEMALE PATIENT OVER 65

SCREENING	FREQUENCY
Bone Density Screen	Every 2 Years
Cardio Disease Screen (Lipid Panel to include Cholesterol, HDL Cholesterol, Triglycerides)	Every 5 Years
Colonoscopy Screen	Every 10 years
Depression Screen	Annually (12 months)
Mammogram	Annually (12 months)
Pap Smear/Pelvic Exam	Variable/Every 5 Years
IMMUNIZATIONS	**FREQUENCY**
Influenza (Flu)	Once Per Flu Season
Pneumococcal-13 valent Pneumococcal-23 valent	Once Once, one year after receiving Pneumococcal-13 valent
Tetanus/Diptheria	Every 10 Years