RICHTER
Family Medicine
& Wellness

5500 W. Friendly Ave Ste 201
Greensboro, NC 27410
Office: 336-897-0004
Fax:336-897-3003
Richterfamilymedicinewellness@gmail.com

Chart # _____

Medical History Form

Name: _____ **Age**: _____**DOB**:_____

Past Medical History (examples: diabetes, high blood pressure, hypercholesterolemia) If None: Check Here _____

1. _____ 6._____ 11._____
2. _____ 7._____ 12._____
3. _____ 8._____ 13._____
4. _____ 9._____ 14._____
5. _____10. _____ 15._____

Hospitalizations/ Surgeries: (such as appendectomy or tonsillectomy) If none: check here_____

1. _____ 4._____7._____
2. _____ 5._____8._____
3. _____ 6._____9._____

Family History: (check all that apply) If no family history of medical problems, check here_____

Problem:	High Blood Pressure	Diabetes	Heart Attack (What age?)	Cholesterol	Stroke (What age?)	Cancer/Type	Deceased
Father							
Mother							
Brother							
Sister							
Maternal Grandmother							
Maternal Grandfather							
Paternal Grandmother							
Paternal Grandfather							

Health Maintenance: Please indicate when the last time you had the following:

Mammogram	TDAP
Pap Smear	Flu Vaccine
Bone Density	Prevnar Vaccine
Colonoscopy	Pneumococcal Vaccine
Cologuard	Shingles Vaccine

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Current Medications

Name:_____ Age: _____DOB:_____

Medication Name	Strength & Dose	How often you take this medication?

Allergies to Medications: _____

_____

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Social History:

Tobacco: Packs Daily (Circle): (0) (1/2) (1) (1 ½) (2) (2 ½) (3+) Recreational Drug Use: (Circle): Yes No
Explain: _____

Alcohol: (Circle): Frequency: none rare weekly daily Type: Beer wine liquor Amount: 0 1 2 3 4 5+
(Circle One): Single Married Separated Divorced Widowed Occupation: _____

Children?: Yes_____ No_____ If yes, Ages/Names_____
Do you: Examine your skin monthly? Yes___ No ___ Frequency per week of vigorous exercise: 0 1 2 3 4 5+
(Women) Perform monthly breast exams? Yes No (Men) Perform monthly testicular exams? Yes No
Wear a seat belt? Yes No Faith Background_____
Have you ever been abused? (circle) Yes No
Physically _____ Sexually _____ Verbally _____ Emotionally _____

Fall Risk Assessment:

How many falls have you had in the last 12 months? (Circle): 0 1 2 3 4 5+ or more
Did you suffer any significant injury due to the fall in the last 12 months? No _____ Yes_____
If yes, please explain:_____
_____
Would you like information to help you identify hazards in your house that might harm you? No_____ yes____

Functional Ability:

1. Are you able to climb stairs? Up _____ Down _____ Yes _____ No____ Find it difficult _____
2. Are you able to exercise? Yes_____ No____ Find it difficult _____
3. Are you able to get in and out of your cars? Yes_____ No____ Find it difficult _____
4. Are you able to kneel? Yes _____ No____ Find it difficult _____
5. Are you able to perform activities of daily living? Yes _____ No____ Find it difficult _____
6. Are you able to walk? ½ mile ____ 1 mile ____ 2 miles ____ 3 miles _____ 5 miles _____ 10 miles _____

Review of Systems: Do you have any symptoms related to these areas?

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Eyes/ Vision	____	____	Heart/Chest	____	___	Skin/Rash	____	____
Ears/ Hearing	____	____	Nerves/Emotions	____	____	Legs/Arms	____	____
Mouth/Nose/Throat	____	____	Stomach/ Abdomen	____	____	Joints/Back	___	____
Lungs/ Breathing	____	____	Groin/Genitals/Rectum	____	____	Last Menstrual cycle: _____		

Please explain your yes answers noted above:
_____
_____
_____

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What to expect from your Medicare Wellness Visit

Elements	What to Expect
History	Review of your medical and social history: Past Medical & Surgical history Current Medications & Supplements Family Medical History History of Alcohol, tobacco, and drug use Diet & Exercise Anything else the provider deems appropriate
Identifying Risk Factors	You complete standardized screening questions for: Depression Hearing Impairment Activities of daily living Fall Risk/ Home Safety Provider reviews results to identify possible risk factors
Health Risk Management (HRA)	In written form- your self- report information including screening questions in Risk Factor categories, self- assessment of health status, psychosocial risks, behavioral risk, etc.
Problem List & Interventions	Establish a list of your risk factors and conditions for which you are being treated or treatment is recommended.
Current Providers/ Suppliers	Establish a list of your current providers and suppliers of healthcare.
Detection of Cognitive Impairment	Through direct observation and discussion with you and/or your family/caregivers, provider will assess if there is any cognitive impairment.
Exam	Obtain the following: Height & Weight and Calculate BMI Blood Pressure Visual acuity screen (eye chart) Anything else provider deems appropriate
Voluntary Advanced Care (end of life) Planning	Upon your consent, gather/provide information on advanced directive and end of life planning. You can decline to discuss.
Personalized Health Advice	Counseling/ education and/ or referral for counseling/ education aimed at preventing chronic diseases, reducing your identified risk factors, promoting wellness, and improving self-management of your health
Screening/ Preventative services schedule	Establish a written screening schedule, covering the next 5-10 years(checklist) of recommended/ appropriate covered preventative services that are covered benefits under Medicare.

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Medicare Wellness Visits

IMPORTANT: The Three Medicare-created *wellness visits* are focused on wellness, risk factor reduction, and prevention. They are not the same as a "routine physical checkup" or "routine annual exam". There continues to be no coverage from Medicare for traditional age-specific physicals.

These three Medicare-created Wellness visits are covered by Medicare at 100% without deductible or coinsurance, if the frequency limits are not exceeded

1. **Welcome to Medicare or IPPE**: once per lifetime in the first 12 months of Part B enrollment

2. **Annual Wellness Visit, initial**: once per lifetime after the first 12 months of Part B enrollment and at least 12 months after a "welcome to Medicare visit" (if applicable)

3. **Annual Wellness Visit, subsequent:** once every 12 months, first one at least 12 months after the initial Annual Wellness Visit

These Wellness visits do not include any clinical laboratory test, but the provider may separately order such tests during one of these visits. All laboratory tests are subject to Medicare's applicable coverage guidelines and frequency limits. Deductible and coinsurance may be applied.

The* Wellness visits* do not include other routine preventative services that Medicare covers (I.E., Pelvic / Breast Exam, Paps smear, Influenza and pneumonia vaccines, smoking cessation, counseling, etc.). These services can be provided alongside one of the wellness visits and billed separately to Medicare. These services are subject to their own Medicare Coverage guidelines and frequency limits. Deductible and coinsurance may be applied.

An additional office visit (E&M) service can be provided alongside one of the wellness visits and billed separately to Medicare if its significant, separate and medically necessary to treat a new or established health problem. This service is subject to its own Medicare coverage and guidelines and limitations. Deductible and coinsurance will be applied.

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Patient Health Questionnaire (PHQ-9)

Name: _____ Age:_____ DOB_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly Everyday
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself- or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
Moving or speaking so slowly that other people 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**
Thoughts that you would be better off dead, or hurting yourself	**0**	**1**	**2**	**3**

Total	

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

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

PHQ-9 Patient Depression Questionnaire **Provider Initials: _____**

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Name: _____ Age: _____ DOB: _____

Please list all current doctors/ providers that are regularly involved in providing medical care to you:

Doctor/ Provider Name:	**Type of Doctor/ Provider:**	**What problem do you see them for?**

Interim History

Have you ever been hospitalized in the last year? _____ Why? _____

Have you ever been to the ER in the last year? _____ Why? _____

Have you identified any new allergies to medications within the last year? _____

Have you started any new medications recently?_ _____

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Medicare Wellness: Patient Packet

Name: _____ DOB:_____

Your appointment is scheduled for _____ at _____ with __Dr. Karen L. Richter, MD.
**** For lab work you will need to be fasting after midnight (or minimum of 6 hours. Water and/or black coffee only. You make take your regular medications.**

_____ Medicare's **"Welcome to Medicare" Visit (IPPE)** *Medicare Wellness*
(Benefit available 1 time in your first 12 months of enrollment with Medicare Part B)

_____ **Medicare's Annual Wellness Visit** * Medicare Wellness*
(For beneficiaries past their first 12 months of Medicare Part B enrollment and 12 months after a welcome to Medicare exam, if received)

_____ **Regular Adult CPX (Physical Exam)**

- Medicare Part B Primary: This service continues to be non-covered by original Medicare Part B. Medicare will deny this service and payment will be your responsibility. If you qualify and would prefer to receive one of Medicare's covered wellness services (i.e. Welcome to Medicare Wellness or Annual Wellness Visit), complete the attached forms and questionnaires and present them at the time of your appointment.)
- Medicare Advantage Primary (i.e. Medicare Part C/Replacement Plan): Please check with your insurance plan to verify your benefits and coverage for this routine annual physical exam service.

Enclosed you will find the Patient Questionnaire Packet required for the covered * Medicare Wellness* Services. Please make sure your name and date of birth are on each page.
It includes:

- Materials explaining the Medicare Wellness benefits and what to expect.
- Health Risk Assessment (HRA) form.
- Depression Screening Questionnaire (PHQ-9)
- List of Providers & Supplier of Health Care Form

Please complete the enclosed questionnaire ***prior to your appointment***. Please bring the completed questionnaire with you to your appointment and give it back to your provider. Your provider will go over these documents as part of your service. If you do not complete it before your appointment, ***you may show up 20 minutes early to complete it.***

Thank you! We look forward to seeing you.