Annual Wellness Visit
Michigan Healthcare Professionals, P.C.

Name (Print): Date of Birth:

Michigan Healthcare Professionals, PC and Medicare want you to receive Wellness Care – Healthcare that may lower your risk for illness or injury. The term "physical" is often used to describe wellness care. Medicare does not fully pay for head-to-toe physical exams. Medicare does pay for wellness visits at no cost to you once per year to identify health risk and help you reduce them. At your wellness visit, our healthcare team will take a complete history and provide several other services:

- **Screenings to detect depression, risk of falling and other problems**
- **A limited exam to check your pulse, blood pressure, weight, heights, and BMI**
- **Recommendations for other wellness services and healthy lifestyles changes**

Before your appointment, you will be asked about your health and will be asked to complete the attached forms. If you arrive 20 minutes or later for your appointment you will have to reschedule your annual wellness visit.

A wellness visit does not deal with new or existing health problems. That would be a separate service and would therefore require a separate visit. Please let our staff know if you need a doctor's help with a health problem, a medication refill or something else, so we can schedule an appointment for you. The Medicare Wellness Visit is just another tool for us to keep you healthy.

After the completion of your Annual Wellness Visit you will get a copy of your customized prevention plan letting you know which screenings and other preventative services you should get.

We hope that you get the most from your Medicare Wellness benefits. Please contact us with any questions.

Thank you,

Michigan Healthcare Professionals, P.C

ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name_____ DOB_____

PLEASE INDICATE THE NAMES OF ANY SPECIALISTS YOU ARE CURRENTLY SEEING:

(ie, Cardiologist, Gastroenterologists, Gynecologist, Pulmonologist, Nephrologist, Neurologist, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PLEASE LIST ALL OF YOUR MEDICATIONS:

Please list all medications that you are currently taking: Include all prescription medication, over the counter medication, and any vitamins/herbal remedies.

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

ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name: Date of Birth:

SOCIALHISTORY:

I currently smoke? Yes No

DEPRESION SCREENING (PHQ-2)

OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	*NOT AT ALL*	*SEVERAL DAYS*	*MORE THAN ONE-HALF THE DAYS*	*NEARLY EVERY DAY*
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

FAMILY HISTORY:

List any Changes in your Family history: (□No change)

FUNCTIONAL ABILITY(ADL):

Do you handle your own medication? Yes No

Do you handle your own finances? Yes No

Do you have an unsteady gait or difficulty walking? Yes No

Are you having trouble performing tasks you've done all your life, like cooking or balancing the checkbook? Yes No

ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name: Date of Birth:

FALL SCREENING: Desmond Fall Risk Questionnaire

Yes	No	Have you had a fall or near fall in the past year?
Yes	No	Do you have a fear of falling that restricts your activity?
Yes	No	Do you experience dizziness or a sensation of spinning when you lie down, tilt your head back, or roll over in bed?
Yes	No	Do you feel uneasy or unsteady when walking down the aisle of a supermarket, or in an area congested with other people?
Yes	No	Do you have difficulty walking in the dark, or on uneven surfaces such as gravel or a Sloped sidewalk?
Yes	No	Do your feet or toes frequently feel unusually hot or cold, numb or tingly?
Yes	No	Do you wear bifocal or trifocal glasses, or is your vision notably better in one eye?
Yes	No	Do you experience loss of balance, or a lightheaded/faint feeling when you stand up?
Yes	No	Do you take medication for depression, anxiety, nerves, sleep or pain?
Yes	No	Do you take four or more prescription medications daily?
Yes	No	Do you feel like your feet just won't go where you want them to go?
Yes while	No	Do you feel like you can't walk a straight line, or are pulled to the side walking?
Yes	No	Has it been longer than six months since you participated in a regular exercise program?
Yes	No	Do you feel that no one really understands how much dizziness and balance problems affect your quality of life?
Yes	No	Are you interested in improving your balance and mobility?

ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name: Date of Birth:

ADVANCED DIRECTIVES:

Please check if you have the following:

□ Advanced Directives □ Durable Power of Attorney □ Living Will □ DNR

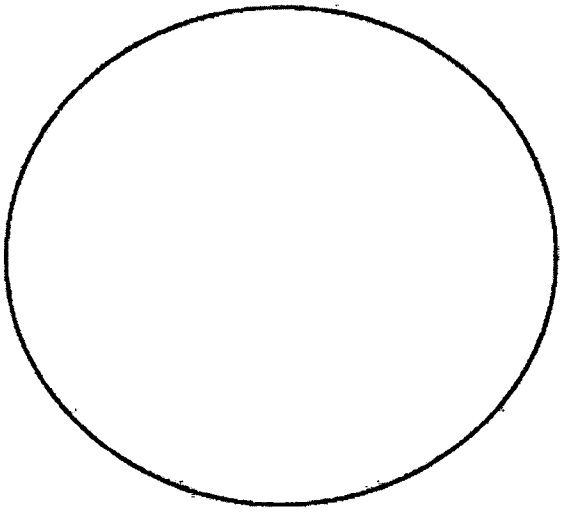
COGNITIVE SCREENING: (PROBLEM WITH MEMORY)

I noticed a decrease in my memory Yes No

Is it difficult for you to remember the names of common objects, like keys or coins? Yes No

CLOCK DRAWING TEST

Draw numbers in the circle to make the circle look like the face of a clock and draw the hands of the clock to read "10 after 11 or 11:10



PREVENTATIVE TESTS:

Please list if you have had any of the following preventative tests:

ANNUAL WELLNESS VISIT

MICHIGAN HEALTHCARE PROFESSIONALS, P.C.

Name: Date of Birth:

General
- ☐ Colonoscopy
  Date_____
- ☐ Bone Density
  Date_____
- ☐ Flu vaccine in the last year
  Date_____
- ☐ Pneumonia vaccine in the last 5 years
  Date_____
- ☐ Tetanus vaccine in the last 10 years
  Date_____
- ☐ Shingles vaccine
  Date_____

History Heart Disease
- ☐ EKG
  Date_____
- ☐ Echocardiogram
  Date_____
- ☐ Cholesterol Screening
  Date_____

Women Only
- ☐ Mammogram
  Date_____
- ☐ Pap Smear
  Date_____

Men Only
- ☐ PSA
  Date_____

Diabetic Patients
- ☐ Hgb A1c
  Date_____
- ☐ LDL
  Date_____
- ☐ Eye Exam
  Date_____

PMH

Have you had any of the following: (Feel free to add comments as you see fit)

Allergies/Hay Fever	Yes	No	High Cholesterol	Yes	No
Alcoholism/Drug Abuse	Yes	No	High Blood Pressure	Yes	No
Anemia/Low Blood Count	Yes	No	Kidney Stones	Yes	No
Arthritis	Yes	No	Kidney Problems	Yes	No
Asthma	Yes	No	Liver Problems	Yes	No
Back Problems	Yes	No	Osteoporosis	Yes	No
Breathing Problems (COPD or Emphysema)	Yes	No	Prostate Problems	Yes	No
			Seizures/Epilepsy	Yes	No
Cancer	Yes	No	Sickle Cell Disease	Yes	No
Type:			Stroke	Yes	No
Diabetes	Yes	No	Stomach Problems	Yes	No
Depression	Yes	No	Thyroid Disease	Yes	No
Glaucoma	Yes	No			
Heart Trouble	Yes	No	**Please add others:**		
Headaches(migraine)	Yes	No			

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Permission for use granted by Richard Brown, MD.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 figety 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	0	1	2	3
add columns			+	+
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you 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 _____

Advanced Directives

Advance Planning: What Everyone Needs to Know

A time may come when an accident or illness, short-term or permanent, will prevent you from making and communicating your own medical-care decisions. ***Advance planning*** is an action you can take while you are well. ***Advanced planning*** can help ensure that your wishes will be followed if you can't speak for yourself. Advanced planning can take any three forms:

·A living will ·A durable power of attorney ·Written or spoken instructions to family, friend, and a doctor

Why do you need advance Planning?

Technology advances have enabled doctors to save lives and improve the quality of life. Sometimes, however, technology prolongs life where there is no hope for recovery. It is then when a decision must be made about whether to use life-support and for how long. **Advance planning** helps ensure that your wishes about the use of life support will be honored.

People have started to hear the terms **"living wills," durable power of attorney for health care,"** and **"advanced directives."** Their use in the media has increased since the U.S. Supreme Court decision in the Nancy Cruzan case. In that case, treatment was continued despite family objections because there was no clear proof of Ms. Cruzan's wishes.

Another reason the terms are heard so often is that the federal government has recently passed the Patient Self Determination Act. This ruling requires medical-care facilities to inform patients of their rights, under state law, to accept or reject treatment and to make their wishes known in advance.

Advance planning methods

Living wills and **durable powers of attorney for medical care** are formal, legally binding methods for stating your wishes about future treatment. They are called **Advance Directives.**

A **living will** lets you make a formal written statement about future medical care under various circumstances. **Living wills** are often applied only in terminal-care situations. (The definitions of "terminal" vary from state to state.)

A **durable power of attorney for medical care** lets you appoint someone to act on your behalf if you cannot speak for yourself. You actually give a family member or friend (who is at least 18 years of age) the authority to act as a patent advocate and make sure your instructions are followed.

Laws for formal **advanced directives** (especially **living wills**) vary greatly from state to state as to format, methods of implementation and to what medical conditions the document applies.

Living Will

To My Family, My Physician, My Clergyman & My Substitute Decision Maker in the Durable Power of Attorney:

I, _____, being of sound mind, make this statement as an indication of my choice of medical care and as a directive to be followed if I become unable to participate in decisions regarding my health care. These instructions reflect my commitment to decline medical treatment under circumstances indicated below.

I direct my attending physician to withhold or withdraw treatment that serves only to prolong the process of my dying if I should be in incurable or irreversible physical condition with no reasonable expectation of recovery.

These instructions apply if I am: (a) in a terminal condition; or (b) permanently unconscious; or (c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct the treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

If I am in any one of the conditions described above, I have indicated my wishes in regard to the following forms of treatment:

Cardiac Resuscitation	☐ I do want	☐ do not want
Mechanical Respiration	☐ I do want	☐ do not want
Feeding Tubes	☐ I do want	☐ do not want
Kidney Dialysis	☐ I do want	☐ do not want
Chemotherapy	☐ I do want	☐ do not want
Antibiotics	☐ I do want	☐ do not want
Intravenous Fluids	☐ I do want	☐ do not want

Additional Instruction: _____

_____

These directives express my right to refuse treatment and they are my instructions to my substitute decision maker as constituted in the Durable Power of Attorney instrument. I intend that my instructions be carried out unless I have rescinded them in a new written declaration by a clear oral expression that I have changed my mind.

By signing this form, I hereby consent to this discussion with my physician/provider.

_____ ____/____/_____
Signature Date

_____ ____/____/_____
Physician/Provider Date

My designated decision maker is: _____
Whose current address and phone number is: _____

The standard operating procedures of most health care facilities assume that you would want life sustaining procedures provided unless you indicate otherwise.

Durable Power of Attorney for Health Care

I, _____ of _____, Michigan,
(Name) (City)
hereby appoint _____,
(Durable Power of attorney for health care/Patient Advocate)
As my attorney in fact (herein called patient advocate) with the following power to be exercised in my name and for my benefit, including, but not limited to, making decisions regarding my care, custody or medical treatment. This power of attorney has effect only if I become unable to participate in medical treatment decisions.

If the first individual is unable, unwilling or unavailable to serve as my patient advocate, then:
I designate: _____ residing at
(Successor Advocate Address)
_____. To serve as my patient advocate. With respect to my personal care, my advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person, including, but not limited to:

(If any of the following do not apply, I may cross them out and place my initials next to the cross out.)

A. To have access to and control over my medical and other personal information.
B. To employ and discharge physicians, nurses, therapists and other care providers, and to pay them reasonable compensation.
C. To give an informed consent or an informed refusal on my behalf with respect to any medical care; diagnostic, surgical, or therapeutic procedure; or other treatment of any type or nature, including life-sustaining treatments such as artificial nutrition and hydration.
D. To execute waivers, medical authorizations and such other approval as may be required to permit or authorize care which I may need, or to discontinue care that I am receiving.
E. Decisions that could or would allow my death (except if I am pregnant.)

My advocate shall be guided in making such decisions by what I have told my advocate about personal preferences regarding such care. Some of those preferences may be recorded below:
(Recording any of your preferences is OPTIONAL.)

My wishes concerning care are as follows: _____
_____
_____
_____

It is my intent that my family, the medical facility, and my doctors, nurses and other medical personnel involved in my care not be liable for implementing the decisions of my patient advocate or honoring wishes expressed in this designation.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document. This document is to be treated as a Durable Power of Attorney and shall survive my disability or incapacity.

This document is signed in the state of Michigan. It is my intent that the laws of the state of Michigan govern all questions concerning its validity, the construction of its provisions and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be.

Durable Power of Attorney Health Care (continued)

I voluntarily sign this Durable Power of Attorney after careful consideration. I understand its meaning and accept its consequences.

_____ Signature

_____/_____/_____ Date

_____ Printed Name

_____-_____-_____ Social Security Number

Witnesses:

(A witness shall not sign this Durable Power of Attorney unless the person appears to be of sound mind and under no duress, fraud, or under influence.)

_____ Witness 1 Signature

_____ Printed Name

_____ Street Address

_____ City, State, Zip Code

_____ Phone Number

_____ Witness 2 Signature

_____ Printed Name

_____ Street Address

_____ City, State, Zip Code

_____ Phone Number

(A witness must be a disinterested individual and may not be the person's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, physician, patient advocate, and employee of a life or health insurance provider for the patient, an employee of a health facility that is treating the patient, or an employee of a home-for-the-aged.)

Well Visit, Over 65: Care Instructions

Your Care Instructions

Physical exams can help you stay healthy. Your doctor has checked your overall health and may have suggested ways to take good care of yourself. He or she also may have recommended tests. At home, you can help prevent illness with healthy eating, regular exercise, and other steps.

Follow-up care is a key part of your treatment and safety. Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

How can you care for yourself at home?

- Reach and stay at a healthy weight. This will lower your risk for many problems, such as obesity, diabetes, heart disease, and high blood pressure.
- Get at least 30 minutes of exercise on most days of the week. Walking is a good choice. You also may want to do other activities, such as running, swimming, cycling, or playing tennis or team sports.
- Do not smoke. Smoking can make health problems worse. If you need help quitting, talk to your doctor about stop-smoking programs and medicines. These can increase your chances of quitting for good.
- Protect your skin from too much sun. When you're outdoors from 10 a.m. to 4 p.m., stay in the shade or cover up with clothing and a hat with a wide brim. Wear sunglasses that block UV rays. Even when it's cloudy, put broad-spectrum sunscreen (SPF 30 or higher) on any exposed skin.
- See a dentist one or two times a year for checkups and to have your teeth cleaned.
- Wear a seat belt in the car.
- Limit alcohol to 2 drinks a day for men and 1 drink a day for women. Too much alcohol can cause health problems.

Follow your doctor's advice about when to have certain tests. These tests can spot problems early.

For men and women

- **Cholesterol.** Your doctor will tell you how often to have this done based on your overall health and other things that can increase your risk for heart attack and stroke.
- **Blood pressure.** Have your blood pressure checked during a routine doctor visit. Your doctor will tell you how often to check your blood pressure based on your age, your blood pressure results, and other factors.
- **Diabetes.** Ask your doctor whether you should have tests for diabetes.
- **Vision.** Experts recommend that you have yearly exams for glaucoma and other age-related eye problems.
- **Hearing.** Tell your doctor if you notice any change in your hearing. You can have tests to find out how well you hear.
- **Colon cancer tests.** Keep having colon cancer tests as your doctor recommends. You can have one of several types of tests.
- **Heart attack and stroke risk.** At least every 4 to 6 years, you should have your risk for heart attack and stroke assessed. Your doctor uses factors such as your age, blood pressure, cholesterol, and whether you smoke or have diabetes to show what your risk for a heart attack or stroke is over the next 10 years.
- **Osteoporosis.** Talk to your doctor about whether you should have a bone density test to find out whether you have thinning bones. Also ask your doctor about whether you should take calcium and vitamin D supplements.

For women

- **Pap test and pelvic exam.** You may no longer need a Pap test. Talk with your doctor about whether to stop or continue to have Pap tests.
- **Breast exam and mammogram.** Ask how often you should have a mammogram, which is an X-ray of your breasts. A mammogram can spot breast cancer before it can be felt and when it is easiest to treat.
- **Thyroid disease.** Talk to your doctor about whether to have your thyroid checked as part of a regular physical exam. Women have an increased chance of a thyroid problem.

For men

- **Prostate exam.** Talk to your doctor about whether you should have a blood test (called a PSA test) for prostate cancer. Experts disagree on whether men should have this test. Some experts recommend that you discuss the benefits and risks of the test with your doctor.
- **Abdominal aortic aneurysm.** Ask your doctor whether you should have a test to check for an aneurysm. You may need a test if you ever smoked or if your parent, brother, sister, or child has had an aneurysm.

Preventing Falls: Care Instructions

Your Care Instructions

Getting around your home safely can be a challenge if you have injuries or health problems that make it easy for you to fall. Loose rugs and furniture in walkways are among the dangers for many older people who have problems walking or who have poor eyesight. People who have conditions such as arthritis, osteoporosis, or dementia also have to be careful not to fall.

You can make your home safer with a few simple measures.

Follow-up care is a key part of your treatment and safety. Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

How can you care for yourself at home?

Taking care of yourself

- You may get dizzy if you do not drink enough water. To prevent dehydration, drink plenty of fluids, enough so that your urine is light yellow or clear like water. Choose water and other caffeine-free clear liquids. If you have kidney, heart, or liver disease and have to limit fluids, talk with your doctor before you increase the amount of fluids you drink.
- Exercise regularly to improve your strength, muscle tone, and balance. Walk if you can. Swimming may be a good choice if you cannot walk easily.
- Have your vision and hearing checked each year or any time you notice a change. If you have trouble seeing and hearing, you might not be able to avoid objects and could lose your balance.
- Know the side effects of the medicines you take. Ask your doctor or pharmacist whether the medicines you take can affect your balance. Sleeping pills or sedatives can affect your balance.

- Limit the amount of alcohol you drink. Alcohol can impair your balance and other senses.
- Ask your doctor whether calluses or corns on your feet need to be removed. If you wear loose-fitting shoes because of calluses or corns, you can lose your balance and fall.
- Talk to your doctor if you have numbness in your feet.

Preventing falls at home

- Remove raised doorway thresholds, throw rugs, and clutter. Repair loose carpet or raised areas in the floor.
- Move furniture and electrical cords to keep them out of walking paths.
- Use nonskid floor wax, and wipe up spills right away, especially on ceramic tile floors.
- If you use a walker or cane, put rubber tips on it. If you use crutches, clean the bottoms of them regularly with an abrasive pad, such as steel wool.
- Keep your house well lit, especially stairways, porches, and outside walkways. Use night-lights in areas such as hallways and bathrooms. Add extra light switches or use remote switches (such as switches that go on or off when you clap your hands) to make it easier to turn lights on if you have to get up during the night.
- Install sturdy handrails on stairways.
- Move items in your cabinets so that the things you use a lot are on the lower shelves (about waist level).
- Keep a cordless phone and a flashlight with new batteries by your bed. If possible, put a phone in each of the main rooms of your house, or carry a cell phone in case you fall and cannot reach a phone. Or, you can wear a device around your neck or wrist. You push a button that sends a signal for help.
- Wear low-heeled shoes that fit well and give your feet good support. Use footwear with nonskid soles. Check the heels and soles of your shoes for wear. Repair or replace worn heels or soles.
- Do not wear socks without shoes on wood floors.
- Walk on the grass when the sidewalks are slippery. If you live in an area that gets snow and ice in the winter, sprinkle salt on slippery steps and sidewalks.

Preventing falls in the bath

- Install grab bars and nonskid mats inside and outside your shower or tub and near the toilet and sinks.
- Use shower chairs and bath benches.
- Use a hand-held shower head that will allow you to sit while showering.
- Get into a tub or shower by putting the weaker leg in first. Get out of a tub or shower with your strong side first.
- Repair loose toilet seats and consider installing a raised toilet seat to make getting on and off the toilet easier.
- Keep your bathroom door unlocked while you are in the shower.

Hearing Loss: Care Instructions

Your Care Instructions

Hearing loss is a sudden or slow decrease in how well you hear. It can range from mild to severe. Permanent hearing loss can occur with aging. It also can happen when you are exposed long-term to loud noise. Examples include listening to loud music, riding motorcycles, or being around other loud machines.

Hearing loss can affect your work and home life. It can make you feel lonely or depressed. You may feel that you have lost your independence. But hearing aids and other devices can help you hear better and feel connected to others.

Follow-up care is a key part of your treatment and safety. Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

How can you care for yourself at home?

- Avoid loud noises whenever possible. This helps keep your hearing from getting worse.
- Always wear hearing protection around loud noises.
- Wear a hearing aid as directed. See a person who can help you pick a hearing aid that fits you.
- Have hearing tests as your doctor suggests. They can show whether your hearing has changed. Your hearing aid may need to be adjusted.
- Use other devices as needed. These may include:
    - Telephone amplifiers and hearing aids that can connect to a television, stereo, radio, or microphone.
    - Devices that use lights or vibrations. These alert you to the doorbell, a ringing telephone, or a baby monitor.

    - Television closed-captioning. This shows the words at the bottom of the screen. Most new TVs can do this.
    - TTY (text telephone). This lets you type messages back and forth on the telephone instead of talking or listening. These devices are also called TDD. When messages are typed on the keyboard, they are sent over the phone line to a receiving TTY. The message is shown on a monitor.
- Use pagers, fax machines, and email if it is hard for you to communicate by telephone.
- Try to learn a listening technique called speech-reading. It is not lip-reading. You pay attention to people's gestures, expressions, posture, and tone of voice. These clues can help you understand what a person is saying. Face the person you are talking to, and have him or her face you. Make sure the lighting is good. You need to see the other person's face clearly.
- Think about counseling if you need help to adjust to your hearing loss.

When should you call for help?

Watch closely for changes in your health, and be sure to contact your doctor if:

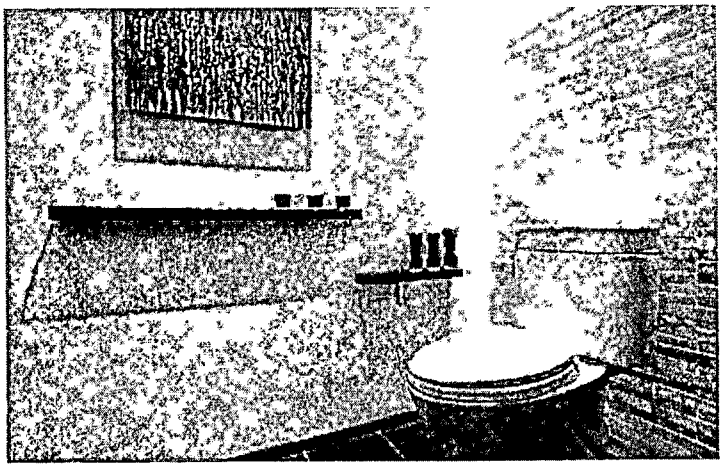
- You think your hearing is getting worse.
- You have new symptoms, such as dizziness or nausea.

Where can you learn more?

Go to https://www.healthwise.net/patientEd

Enter **R798** in the search box to learn more about **"Hearing Loss: Care Instructions".**

Bladder Training: Care Instructions



Your Care Instructions

Bladder training is used to treat urge incontinence and stress incontinence. Urge incontinence means that the need to urinate comes on so fast that you can't get to a toilet in time. Stress incontinence means that you leak urine because of pressure on your bladder. For example, it may happen when you laugh, cough, or lift something heavy.

Bladder training can increase how long you can wait before you have to urinate. It can also help your bladder hold more urine. And it can give you better control over the urge to urinate.

It is important to remember that bladder training takes a few weeks to a few months to make a difference. You may not see results right away, but don't give up.

Follow-up care is a key part of your treatment and safety. Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

How can you care for yourself at home?

Work with your doctor to come up with a bladder training program that is right for you. You may use one or more of the following methods.

Delayed urination

- In the beginning, try to keep from urinating for 5 minutes after you first feel the need to go.
- While you wait, take deep, slow breaths to relax. Kegel exercises can also help you delay the need to go to the bathroom.

- After some practice, when you can easily wait 5 minutes to urinate, try to wait 10 minutes before you urinate.
- Slowly increase the waiting period until you are able to control when you have to urinate.

Scheduled urination

- Empty your bladder when you first wake up in the morning.
- Schedule times throughout the day when you will urinate.
- Start by going to the bathroom every hour, even if you don't need to go.
- Slowly increase the time between trips to the bathroom.
- When you have found a schedule that works well for you, keep doing it.
- If you wake up during the night and have to urinate, do it. Apply your schedule to waking hours only.

Kegel exercises

These tighten and strengthen pelvic muscles, which can help you control the flow of urine. To do Kegel exercises:

- Squeeze the same muscles you would use to stop your urine. Your belly and thighs should not move.
- Hold the squeeze for 3 seconds, and then relax for 3 seconds.
- Start with 3 seconds. Then add 1 second each week until you are able to squeeze for 10 seconds.
- Repeat the exercise 10 to 15 times a session. Do three or more sessions a day.

When should you call for help?

Watch closely for changes in your health, and be sure to contact your doctor if:

- Your incontinence is getting worse.
- You do not get better as expected.

Where can you learn more?

Go to https://www.healthwise.net/patientEd

Enter **V684** in the search box to learn more about **"Bladder Training: Care Instructions".**