MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Today’s Date: _______________

The Annual Wellness Visit is for preventative health and provided by Medicare. This is not a visit to evaluate new or ongoing medical problems, and does not cover the management of medical problems such as labs/prescriptions/etc. Should you need an appointment for a medical problem, a co-pay would be required and it would need to be scheduled as a separate appointment.

Is this information provided by the patient? ☐ Yes ☐ No

If not, who is providing the information? ________________________________

In general, how would you rate your current health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

CURRENT MEDICINES AND MEDICAL CONDITIONS

☐ I don’t take medications (if checking this box please continue on to page 2)

During the past WEEK, how often did you forget to take or decide not to take one or more of your medications?
☐ Never ☐ Sometimes ☐ Usually ☐ Always

How sure are you that you understand the reason why you take each of your medications?
☐ Very sure ☐ Somewhat sure ☐ Not very sure

How confident are you that you can manage your medical conditions from day-to-day?
☐ Very confident ☐ Somewhat confident ☐ Not very confident
ACTIVITIES OF DAILY LIVING

In the past WEEK, have you needed help with any of the following activities?

- Using the toilet: □ YES □ NO
- Dressing: □ YES □ NO
- Getting in/out of chairs: □ YES □ NO
- Eating: □ YES □ NO
- Bathing: □ YES □ NO
- Making it to the restroom: □ YES □ NO
- Taking medications: □ YES □ NO
- Laundry/housework: □ YES □ NO
- Shopping: □ YES □ NO
- Managing money: □ YES □ NO
- Using the telephone: □ YES □ NO
- Preparing meals: □ YES □ NO
- Traveling: □ YES □ NO

In the last YEAR, have you lost your urine and gotten wet?
□ YES □ NO

HEARING

Do you have concerns about your hearing?
□ YES □ NO

If YES, would you like to schedule further evaluation of your hearing?
□ YES □ NO

MEMORY

In the last MONTH, how often did you have trouble remembering/thinking clearly?
□ Never □ Sometimes □ Usually □ Always

FALLS

Do you feel unsteady on your feet?
□ YES □ NO

Do you worry about falling?
□ YES □ NO

Have you fallen in the past YEAR?
□ YES □ NO

Number of times: __________

Were you injured?
□ YES □ NO

Have you had dizziness in the last 6 MONTHS?
□ YES □ NO

Do you use any assistive devices for walking?
□ YES □ NO

If yes, which ones?
□ Another person
□ Railing/objects around the house
□ Cane
□ Walker
□ Wheelchair

Do you have scattered rugs in your home?
□ YES □ NO

EYESIGHT

Because of your eyesight, do you have trouble driving a car, watching TV, reading, or doing daily activities?
□ YES □ NO

Last eye exam: ____________________________
# Hospital & ER Visits

During the past 6 months, how many times did you go to the emergency room?
- None
- 1 or more times

Do you think you will go back to the emergency room again in the next 6 months?
- Not likely
- Possibly likely
- Very likely

During the past 6 months, how many times did you stay in the hospital overnight as a patient?
- None
- 1 or more times

Do you think you will go back to the hospital again in the next 6 months?
- Not likely
- Possibly likely
- Very likely

# Past Surgeries

What surgeries have you had since your last wellness visit?
- ____________________________
- ____________________________

# Exercise

In general, how many days do you exercise each week? ________________ days

On days when you exercise, how long do you exercise? ________________ minutes

How often do you do exercises to strengthen your arms and legs? ______ days

When you exercise, how intense is your typical exercise?
- Light (stretching/slow walking)
- Moderate (brisk walking)
- Heavy (jogging/swimming)
- Very heavy (fast running/climbing)

# Home Medical Equipment

Do you use home medical equipment?
- YES
- NO

Who do you receive your home medical equipment from?
- ____________________________
- ____________________________

# Caffeine Use

Do you drink caffeine daily?
- YES
- NO

If yes, how many servings per day? _______

# Tobacco Use

Please indicate your tobacco history:
- Current tobacco user
  - _____ packs per day
  - _____ cans per day
- Former tobacco user
  - Quit date: ____________________
  - Previously used:
    - _____ packs per day
    - _____ cans per day
- Never used tobacco

# Alcohol Use

In a given week, how many days do you drink alcohol? _____________ days

Do you ever drink more than 4 drinks in one sitting?
- YES
- NO
### OTHER DRUG USE

Do you use any drugs for non-medical reasons?

- [ ] YES
- [ ] NO

### FAMILY HISTORY

Have any of your immediate family members (parents, siblings, or children, living or deceased) had the following diseases?

- **Heart Attack**
  - [ ] YES
  - [ ] NO
  - If yes, who: ___________________________

- **Stroke**
  - [ ] YES
  - [ ] NO
  - If yes, who: ___________________________

- **Diabetes**
  - [ ] YES
  - [ ] NO
  - If yes, who: ___________________________

- **Cancer**
  - [ ] YES
  - [ ] NO
  - If yes, who and what type of cancer:
    ___________________________

### LIVING SITUATION

Who lives with you? ___________________________

If you live alone, who can you call if you need help?

- **Contact Name:** ___________________________
- **Contact phone number:** ___________________________

Do you have any animals/pets?

- [ ] YES
- [ ] NO

- **Type of pets:** ___________________________

### BARRIERS TO CARE

Do you have any problems getting the care you need because of any of the following reasons?

- [ ] Affording medications
- [ ] Transportation/driving to appointments
- [ ] Increased stress in your life
- [ ] Other: ___________________________

### VEHICLE SAFETY

Do you always wear a seatbelt when driving?

- [ ] YES
- [ ] NO

### NUTRITION

What type of diet do you follow?

_________________________

### ACTIVITIES:

What activities do you enjoy doing?

_________________________

### PAST SCREENINGS / DATES:

- **Colon Cancer Screening:** ___________________________
- **Bone Density Screening:** ___________________________
- **Mammogram:** ___________________________
- **Lung Cancer Screening:** ___________________________
- **Abdominal Aortic Aneurysm:** ___________________________
- **PSA Screening:** ___________________________
- **Tetanus Vaccine:** ___________________________
- **Flu Vaccine:** ___________________________
- **Pneumonia Vaccine:** ___________________________
- **Shingrix Vaccine:** ___________________________
DEPRESSION SCREENING:

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

Little interest or pleasure in doing things
- □ Not at all  □ Several days  □ More than half the days  □ Nearly every day

Feeling down, depressed, or hopeless
- □ Not at all  □ Several days  □ More than half the days  □ Nearly every day

SPECIALTY PROVIDERS:

Outside of The Family Health Centers, list all physicians/providers you currently see:

Allergy: ________________________________  Oncology (Cancer): ________________________________
Cardiologist (Heart): ____________________  Ophthalmology (Eye Doctor): ________________
Dermatology (Skin): ______________________  Physical Therapy: __________________________
Gastroenterology (Stomach/Liver): ________  Podiatry (Foot): ___________________________
                                                                                       Pain: ________________________________
Endocrinology (Diabetes, Thyroid): ________  Pulmonology (Lungs): ______________________
                                                                                       Rheumatology: ________________________
Head, Neck, and Ear: _____________________  Urology (Bladder): __________________________
Nephrologist (Kidney): ___________________  Other: ________________________________
Neurology: ______________________________
OB/GYN: ________________________________

ADVANCE DIRECTIVES

Do you have a living will?
- □ YES  □ NO

If you haven’t already, please bring a copy of your living will to the office at your convenience.

Do you have a Durable (healthcare) Power of Attorney?
- □ YES  □ NO

If yes, who is it? ________________________________________________________________