

PATIENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_



**THE  
FAMILY HEALTH  
CENTERS**

ASHEVILLE | ARDEN | HOMINY VALLEY

## 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?

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## 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?

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## 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? \_\_\_\_\_