Medicare Annual Wellness Visit Questionnaire

Name: _____ DOB: _____ Today's Date: _____

List any current medical problems or conditions

1) _____ 6 _____
2) _____ 7 _____
3) _____ 8 _____
4) _____ 9 _____

List Recent Hospital Stays

Reason	Date
1) _____	_____
2) _____	_____
3) _____	_____

Current Physicians/Practitioners

Name/Specialty	Name/Specialty
1) _____	4) _____
2) _____	5) _____
3) _____	6) _____

List any medication that you currently take

Name	Strength	Direction	Prescribed by
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____

Patient Name: _____ Date of Birth:_____

Social History

Do you drink alcohol?..... ☐ Yes ☐ No

if yes how much? _____

Are others concerned about your drinking?..... ☐ Yes ☐ No

Diet: ___Balanced ___Vegetarian ___Diabetic ___Low salt ___Low Fat ___Low Carb
Other_____

Education: ___High School ___College___ Some College ___ Trade School
Other_____

Do you do some form of regular exercise every day?..... ☐ Yes ☐ No

If yes, how much? _____

Marital Status: ___Married ___Single ___Divorced ___ Widowed Other_____

Do you wear seatbelts?..... ☐ Yes ☐ No

Have you ever smoked or chewed tobacco?..... ☐ Yes ☐ No

If yes how much? _____ If you quit, when? _____

Routine Tasks: Please indicate if you do or do not need help performing these routine tasks

1) Feeding yourself ☐ Yes ☐ No If yes, who helps? _____
2) Getting from bed to chair ☐ Yes ☐ No If yes, who helps? _____
3) Getting to the toilet ☐ Yes ☐ No If yes, who helps? _____
4) Getting dressed ☐ Yes ☐ No If yes, who helps? _____
5) Bathing or showering ☐ Yes ☐ No If yes, who helps? _____
6) Walking across the room (includes using cane or walker) ☐ Yes ☐ No If yes, who helps? _____
7) Using the telephone ☐ Yes ☐ No If yes, who helps? _____
8) Taking your medicines ☐ Yes ☐ No If yes, who helps? _____
9) Preparing meals ☐ Yes ☐ No If yes, who helps? _____
10) Managing Money ☐ Yes ☐ No If yes, who helps? _____
11) Moderately strenuous housework as doing the laundry ☐ Yes ☐ No If yes, who helps? _____
12) Shopping for personal items like toiletries or medicines ☐ Yes ☐ No If yes, who helps? _____
13) Shopping for groceries ☐ Yes ☐ No If yes, who helps? _____
14) Driving ☐ Yes ☐ No If yes, who helps? _____
15) climbing a flight of stairs ☐ Yes ☐ No If yes, who helps? _____

Patient Name: _____ Date of Birth:_____

Health Maintenance

Please record the last year you had the following. If you do not know, leave blank

IMMUNIZATIONS		OTHER	DATE
Tetanus Diphtheria	☐ Yes ☐ No	Mammogram	
Flu	☐ Yes ☐ No	Bone Density	
Pneumonia Vaccine	☐ Yes ☐ No	Colonoscopy	
		Glaucoma Exam	
		Hearing Exam	

HEARING: Check Yes, No or Sometimes for each question.

1) Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?..... ☐ Yes ☐ No ☐ Sometimes
2) Do you sometimes feel that people are mumbling or not speaking clearly?..... ☐ Yes ☐ No ☐ Sometimes
3) Do you sometimes find it difficult to understand a speaker at a public meeting?..... ☐ Yes ☐ No ☐ Sometimes
4) Do you find yourself asking people to speak up or repeat themselves?..... ☐ Yes ☐ No ☐ Sometimes
5) Do you sometimes have difficulty understanding speech on the telephone?..... ☐ Yes ☐ No ☐ Sometimes
6) Do you feel handicapped by a hearing problem? ☐ Yes ☐ No ☐ Sometimes
7) Do you experience ringing or noises in your ears? ..... ☐ Yes ☐ No ☐ Sometimes
8) Have you had any significant noise exposure during work, recreation, or military service?..... ☐ Yes ☐ No ☐ Sometimes

Patient Name: _____ Date of Birth:_____

Fall Risk Screening

1) Do you feel like you are unsteady regularly, like you might fall? ☐ Yes ☐ No
2) Have you fallen in the past year? ☐ Yes ☐ No
3) If yes, circle the circumstance surrounding the fall.
   Answers:
   Tripped over something
   Lightheadedness or palpitations prior to
   Loss of consciousness
   Injured
   Needed to see a doctor
   Able to get up on own

Depression Screening

Please circle one for each question. In the past two months have you had the following:

	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