Medicare Annual Wellness Visit Questionnaire

Date: __________________________
Name: __________________________ ___________________________ Date of Birth: __________________________

LAST FIRST MIDDLE MM/DD/YYYY

Please write your answer in the space provided.

1) Little interest or pleasure in doing things. __________________________
2) Feeling down, depressed, or hopeless __________________________

Key:
0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly everyday

Please check the appropriate answer.

1) Are you afraid of falling? □ No □ Yes
2) Have you fallen in the past year? □ No □ Yes
3) If yes, check the circumstances surrounding the fall.

Answers:
□ Tripped over something □ Injured
□ Lightheadedness or palpitations prior to □ Needed to see a doctor
□ Loss of consciousness □ Able to get up on own

HEARING: Check YES, NO, or SOME TIMES for each question.

1) Do you wear hearing aids? □ No □ Yes □ Left □ Right □ Both
2) Does a hearing problem cause you to feel embarrassed when meeting new people?
□ No □ Yes □ Sometimes
3) Does a hearing problem cause you to feel frustrated when talking to members of your family?
□ No □ Yes □ Sometimes
4) Do you have difficulty hearing when someone speaks in a whisper?
□ No □ Yes □ Sometimes
5) Do you feel handicapped by a hearing problem?
□ No □ Yes □ Sometimes
6) Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?
□ No □ Yes □ Sometimes
7) Does a hearing problem cause you to attend religious services less often than you would like?
□ No □ Yes □ Sometimes
8) Does a hearing problem cause you to have arguments with family members?
□ No □ Yes □ Sometimes
9) Does a hearing problem cause you difficulty when listening to TV or radio?
□ No □ Yes □ Sometimes
10) Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
□ No □ Yes □ Sometimes
11) Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
□ No □ Yes □ Sometimes

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**HOME SAFETY:**
1) Type of house/apartment/condo  □Apartment/condo  □Assisted Living  □House  
2) Are there stairs?  □Yes  □No  
3) Who lives in the home with you?  □Spouse  □Son/daughter  □Son/daughter & family  □Other family  □Care giver  □Lives alone  □Lives in a group home/assisted living  
4) What do you use to heat/cool your home?  □Oil heat  □Gas heat  □Electric heat pump/AC  □Woodstove/pellet stove/fireplace  □Space heater(s)  □Fans  □Open windows/screens  □In-window air conditioning unit(s)  □Central Air Conditioning  
5) Are these units serviced on a regular basis?  □Yes  □No  
6) Do you have working smoke alarms and carbon monoxide detectors in your home?  □Yes  □No  
7) What home appliances are used to cook in your home?  □Gas oven/gas stove  □Electric oven/electric stove  □Microwave  □Toaster Oven  □Crockpot  □Other–please specify ____________________________  
8) Do you currently drive, and if so—are you aware of any recent accidents or episodes of becoming lost/disoriented in the past year?  □Yes – provide explanation _____________________________________________________________________ □ No  
9) How do you keep track of your daily medications?  □No method used  □Medicines lined up  □Pre-poured or pre-placed pills in a pillbox  □Blister/bubble packs of meds for each day/time  □Other: _______________________________________________________________________________________________  
10) Who administers your medications?  □Self  □Spouse  □Family member  □Care giver  
11) Are any assistive devices used in your home?  □Comfort level toilets  □Portable commodes  □Stair lifts  □Hoyer lift  □Hospital bed  □Chair lift  □Remote patient monitoring  □Grip bars  □Other: _______________________________________________________________________________________________

**List any current medical problems or conditions.**
1) ____________________________________________________________________________  
2) ____________________________________________________________________________  
3) ____________________________________________________________________________  
4) ____________________________________________________________________________  
5) ____________________________________________________________________________  
6) ____________________________________________________________________________  
7) ____________________________________________________________________________  
8) ____________________________________________________________________________

**Last Dilated Retinal Eye Exam:** ___________  
**Provider:** ____________________________

**Physicians/practitioners you currently see**

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<thead>
<tr>
<th>Name / Specialty</th>
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<td>1) _______________</td>
<td>4) _______________</td>
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<td>2) _______________</td>
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<td>3) _______________</td>
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**List any medication that you currently take, including over-the-counter.**

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<th>Name</th>
<th>Strength</th>
<th>Direction</th>
<th>Prescribed by</th>
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ROUTINE TASKS: Please indicate if you do or do not need help performing these routine tasks

1) Feeding yourself □ No □ Yes  If yes, who helps? ____________
2) Getting from bed to chair □ No □ Yes  If yes, who helps? ____________
3) Getting to the toilet □ No □ Yes  If yes, who helps? ____________
4) Getting dressed □ No □ Yes  If yes, who helps? ____________
5) Bathing or showering □ No □ Yes  If yes, who helps? ____________
6) Walking across the room (includes using cane or walker) □ No □ Yes  If yes, who helps? ____________
7) Using the telephone □ No □ Yes  If yes, who helps? ____________
8) Taking your medicines □ No □ Yes  If yes, who helps? ____________
9) Preparing meals □ No □ Yes  If yes, who helps? ____________
10) Managing money (like keeping track of expenses or paying bills) □ No □ Yes  If yes, who helps? ____________
11) Moderately strenuous housework such as doing the laundry □ No □ Yes  If yes, who helps? ____________
12) Shopping for personal items like toiletries or medicines □ No □ Yes  If yes, who helps? ____________
13) Shopping for groceries □ No □ Yes  If yes, who helps? ____________
14) Driving □ No □ Yes  If yes, who helps? ____________
15) Climbing a flight of stairs □ No □ Yes  If yes, who helps? ____________
16) Getting to places beyond walking distance (e.g. by bus, taxi, or car) □ No □ Yes  If yes, who helps? ____________

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

- HepB (shot) __________________________
- Flu vaccine (shot) __________________________
- Pneumonia vaccine (shot) __________________________
- Tetanus Diphtheria vaccine (shot) __________________________
- Zostavax (shot) __________________________
- Abdom. Aortic Aneurysm Screening __________________________
- Bone Density Scan __________________________
- Colonoscopy __________________________
- Diabetes Self Management Training __________________________
- Echocardiogram __________________________
- Eye Glaucoma Exam __________________________
- Glucose __________________________
- Hearing Exam __________________________
- Hemocult __________________________
- Lipid Panel __________________________
- Mammogram __________________________
- Nutritional Therapy __________________________
- Pap Smear __________________________
- Pelvic Exam __________________________
- Prostate Exam __________________________
- PSA Test __________________________
- Rectal Exam __________________________
- Smoking Cessation __________________________

Do you have an Advanced Directive (living will)? □ No □ Yes

Notes: __________________________________________________________

Patient/Authorized Signature: __________________________ Date: ____________

Reviewed by: __________________________ Date: ____________