Maryland Primary Care Physicians

Medicare Annual Wellness Questionnaire

Patient Name:_____ Today's Date:_____(dd/mm/yyyy format)

Date of Birth:_____(dd/mm/yyyy format)

Please answer ALL questions.

1. During the past 2 weeks, how often have you had little interest or pleasure in doing things?
   ○ *Not at all* ○ *Several days* ○ *More than half the days* ○ *Nearly every day*

2. During the past 2 weeks, how often have you been feeling down, depressed, irritable, or hopeless?
   ○ *Not at all* ○ *Several days* ○ *More than half the days* ○ *Nearly every day*

3. Has your physical and emotional health limited your social activities with family, friends, neighbors, or group?
   ○ *Not at all* ○ *Several days* ○ *Moderately* ○ *Quite a bit* ○ *Extremely*

4. How much bodily pain have you generally had?
   ○ *No pain* ○ *Very mild pain* ○ *Mild pain* ○ *Moderate pain* ○ *Severe pain*

5. Was someone available to help you if you needed and wanted help? (example: if you felt very nervous, lonely, or blue, got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help taking care of yourself)
   ○ *Yes, as much as I wanted* ○ *Yes, quite a bit* ○ *Yes, some* ○ *Yes, a little*
   ○ *No, I have no one*

6. How often in the past 4 weeks have you been bothered by sexual problems?
   ○ *Never* ○ *Seldom* ○ *Sometimes* ○ *Often* ○ *Always*

7. How often in the past 4 weeks have you had trouble eating well?
   ○ *Never* ○ *Seldom* ○ *Sometimes* ○ *Often* ○ *Always*

8. How often in the past 4 weeks have you been bothered by teeth or dentures?
   ○ *Never* ○ *Seldom* ○ *Sometimes* ○ *Often* ○ *Always*

9. How often in the past 4 weeks have you had problems using the telephone?
   ○ *Never* ○ *Seldom* ○ *Sometimes* ○ *Often* ○ *Always*

10. How often in the past 4 weeks have you been tired or fatigued?
    ○ Never ○ Seldom ○ Sometimes ○ Often ○ Always

11. How would you rate your health in general?
    ○ *Excellent* ○ *Very good* ○ *Good* ○ *Fair* ○ *Poor*

12. How confident are you that you can control and manage most of your health problems?
    ○ *Very confident* ○ *Somewhat confident* ○ *Not very confident*
    ○ *I don't have health problems*

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13. Can you get places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car.)
    ○ *Yes* ○ *No*

14. Can you shop for groceries or clothes without help?
    ○ *Yes* ○ *No*

15. Can you prepare your own meals?
    ○ *Yes* ○ *No*

16. Can you do your own housework without help?
    ○ *Yes* ○ *No*

17. Can you handle your own money without help?
    ○ *Yes* ○ *No*

18. Are you having difficulties driving your car?
    ○ *Yes, often* ○ *Sometimes* ○ *No* ○ *N/A, I do not use a car*

19. Do you always fasten your seat belt when you are in a car?
    ○ *Yes, usually* ○ *Sometimes* ○ *No* ○ *N/A, I do not use a car*

20. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
    ○ *Yes, quiet often* ○ *Yes, sometimes* ○ *Yes, very little* ○ *No, not at all*

21. Do you wear hearing aids?
    ○ *Yes* ○ *No*

22. Do you have trouble hearing the television or radio when others do not?
    ○ *Yes* ○ *No*

23. Do you have to strain or struggle to hear/understand conversations?
    ○ *Yes* ○ *No*

24. Have you had your vision checked in the past 12 months?
    ○ *Yes* ○ *No*

25. Do have any vision problems?
    ○ *Yes* ○ *No*

26. Have you been bothered by falling or dizziness when standing up?
    ○ *Never* ○ *Seldom* ○ *Sometimes* ○ *Often* ○ *Always*

27. Are you afraid of falling?
    ○ *Yes* ○ *No*

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28. When was the last time you fell?
○ *Within the last year* ○ *Within the last 2 months* ○ *No falls*

29. Have you been given any information to help you with hazards in your house that might hurt you?
○ *Yes* ○ *No*

30. Where do you live?
○ *Apartment/Condo* ○ *House* ○ *Assisted Living* ○ *Nursing Home* ○ *Other*

31. Do you use any of the following?
○ *Cane* ○ *Walker* ○ *Wheelchair* ○ *Scooter* ○ *None*

32. What was the hardest physical activity you could do for at least 2 minutes?
○ *Very heavy* ○ *Heavy* ○ *Moderate* ○ *Light* ○ *Very light*

33. Do you exercise for about 20 minutes three or more days a week?
○ *Yes, most of the time* ○ *Yes, some of the time* ○ *No, I usually do not exercise this much*

34. How do you currently keep track of your medications?
○ *No method used* ○ *Medicines lined up* ○ *Pre-poured or pre-placed pills in pillbox*
○ *Blister/bubble packs of meds for each day/time* ○ *Other*

35. Who administers your medicines?
○ *Self* ○ *Spouse* ○ *Family Member: Who?*_____ ○ *Caregiver*

36. Have you been given any information on keeping track of your medications?
○ *Yes* ○ *No*

37. How often do you have trouble taking medicines the way you have been told to take them?
○ *I do not have to take medications* ○ *I always take them as prescribed*
○ *Sometimes I take them as prescribed* ○ *I seldom take them as prescribed*

38. Do you have a living will or Advance Directive? (If you have one please bring a copy of it with you.)
○ *Yes* ○ *No*