Maryland Primary Care Physicians

Medicare Annual Wellness Visit Questionnaire

Date: _____

Name: _____ _____ _____ Date of Birth: _____
LAST *FIRST* *MIDDLE* *MM/DD/YYYY*

DEPRESSION SCREENING

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*

FALL RISK SCREENING

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*
- ☐ *Lightheadedness or palpitations prior to*
- ☐ *Loss of consciousness*
- ☐ *Injured*
- ☐ *Needed to see a doctor*
- ☐ *Able to get up on own*

HEARING IMPAIRMENT SCREENING

HEARING: *Check YES, NO, or SOMETIMES* 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

Patient Name: _____ **Date of Birth:** _____

HOME SAFETY CHECK LIST

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/fire place ☐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 – 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 _____

CURRENT MEDICAL PROBLEMS

List any current medical problems or conditions.

1)_____ 5)_____
2)_____ 6_____
3)_____ 7)_____
4)_____ 8)_____

PAST MEDICAL HISTORY

Last Dilated Retinal Eye Exam: _____ **Provider:** _____

Physicians/practitioners you currently see

Name / Specialty

1)_____
2)_____
3)_____

Name / Specialty

4)_____
5)_____
6)_____

MEDICATIONS

List any medication that you currently take, including over-the-counter.

Name	Strength	Direction	Prescribed by

Patient Name: _____ **Date of Birth:** _____

SOCIAL HISTORY

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?_____

HEALTH MAINTENANCE

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 _____

ADVANCE DIRECTIVE

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

Notes: _____

_____

_____

Patient/Authorized Signature: _____ Date: _____

Reviewed by: _____ Date: _____