Medicare Annual Wellness Visit Questionnaire

PATIENT DEMOGRAPHICS

Date: _____

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

Home Address: _____ _____ _____ _____ _____
STREET APT/UNIT CITY STATE ZIP

Gender: ☐ Female ☐ Male

Home Phone: _____ Day Phone: _____ Cell Phone: _____

SS #: _____

Next of Kin *(for emergency)*: _____

Name of spouse : _____ Day Phone: _____

Referred by: _____

Insurance: Name _____ Phone # _____

Policy# _____ Group # _____

CURRENT MEDICAL PROBLEMS

List any current medical problems or conditions.

1) _____ 7) _____

2) _____ 8) _____

3) _____ 9) _____

4) _____ 10) _____

5) _____ 11) _____

6) _____ 12) _____

PAST MEDICAL HISTORY

Childhood Illnesses

1) _____ **3)** _____ **5)** _____

2) _____ **4)** _____ **6)** _____

Chronic Illnesses

1) _____ **3)** _____ **5)** _____

2) _____ **4)** _____ **6)** _____

Last Eye/Glaucoma Exam: _____

Past surgeries

Surgery	Date	Surgery	Date
1) _____	_____	**4)** _____	_____
2) _____	_____	**5)** _____	_____

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

PAST MEDICAL HISTORY CONT'D

List any other hospital stays

Reason	Date	Reason	Date
1) _____	_____	4) _____	_____
2) _____	_____	5) _____	_____
3) _____	_____	6) _____	_____

Physicians/practitioners you currently see

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

ALLERGIES

List any allergies to medication, x-ray dyes, or food.

Allergy	**Reaction**
_____	_____
_____	_____
_____	_____

MEDICATIONS

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

Name	Strength	Direction	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

Do you drink alcohol?..... ☐ No ☐ Yes *If yes how much?* _____

Are others concerned about your drinking? ☐ No ☐ Yes

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? ☐ No ☐Yes

If yes, how much? _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Occupation: _____

List everyone in your household including pets:

_____ _____ _____ _____

_____ _____ _____ _____

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

Have you ever smoked or chewed tobacco? ..... ☐No ☐ Yes *If yes, how much?* _____

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

SOCIAL HISTORY CONT'D

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?_____

FAMILY HISTORY

Please list any health problems and causes of death if applicable.

	Living / Deceased	Age	Medical Problems
Father			
Mother			
Brother(s)			
Sister(s)			
Mother's father			
Mother's mother			
Father's father			
Father's mother			

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

HEALTH MAINTENANCE

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

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

HEARING

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

1) Do you find it difficult to follow a conversation in a noisy restaurant or crowded room? ☐ No ☐ Yes ☐ Sometimes
2) Do you sometimes feel that people are mumbling or not speaking clearly? ☐ No ☐ Yes ☐ Sometimes
3) Do you experience difficulty following dialogue in the theater? ☐ No ☐ Yes ☐ Sometimes
4) Do you sometimes find it difficult to understand a speaker at a public meeting or religious service? ☐ No ☐ Yes ☐ Sometimes
5) Do you find yourself asking people to speak up or repeat themselves? ☐ No ☐ Yes ☐ Sometimes
6) Do you find men's voices easier to understand than women's? ☐ No ☐ Yes ☐ Sometimes
7) Do you experience difficulty understanding soft or whispered speech? ☐ No ☐ Yes ☐ Sometimes
8) Do you sometimes have difficulty understanding speech on the telephone? ☐ No ☐ Yes ☐ Sometimes
9) Does a hearing problem cause you to feel embarrassed when meeting new people? ☐ No ☐ Yes ☐ Sometimes
10) Do you feel handicapped by a hearing problem? ☐ No ☐ Yes ☐ Sometimes
11) Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like? ☐ No ☐ Yes ☐ Sometimes
12) Do you experience ringing or noises in your ears? ☐ No ☐ Yes ☐ Sometimes
13) Do you hear better with one ear than the other? ☐ No ☐ Yes ☐ Sometimes
14) Have you had any significant noise exposure during work, recreation, or military service? ☐ No ☐ Yes ☐ Sometimes
15) Have any of your relatives (by birth) had a hearing loss? ☐ No ☐ Yes ☐ Sometimes

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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, circle 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

ADVANCE DIRECTIVE

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

Notes: _____

_____

_____

Authorized Signature: _____ Date: _____

Reviewed by: _____ Date: _____