HEALTHCARE CENTERS
of MORRIS HOSPITAL

MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Date: ____________________ **Date of Birth:** ____________________

Last Name: ____ **First Name:** ______________________ **MI:** _________

PROVIDERS INVOLVED IN YOUR HEALTHCARE

In an effort to ensure optimal care coordination, please list below all providers you see on a regular basis

Provider Name	Specialty

HEARING SCREEN

Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?	☐ Yes	☐ No
Do you sometimes feel that people are mumbling or not speaking clearly?	☐ Yes	☐ No
Do you experience difficulty following dialogue in the theater or while watching TV?	☐ Yes	☐ No
Do you find yourself asking people to speak up or repeat themselves?	☐ Yes	☐ No
Do you sometimes have difficulty understanding speech on the telephone?	☐ Yes	☐ No
Do you experience ringing or noises in your ears?	☐ Yes	☐ No
Do you hear better with one ear than the other?	☐ Yes	☐ No

FUNCTION SCREEN

Do you need helping feeding yourself?	☐ Yes	☐ No
Do you need help getting from bed to chair?	☐ Yes	☐ No
Do you need help getting to the toilet?	☐ Yes	☐ No
Do you need help getting dressed?	☐ Yes	☐ No
Do you need help bathing or showering?	☐ Yes	☐ No

Do you need help walking across the room (includes using cane or walker)?	☐ Yes	☐ No
Do you need help using the telephone?	☐ Yes	☐ No
Do you need help taking your medicines?	☐ Yes	☐ No
Do you need help preparing meals?	☐ Yes	☐ No
Do you need help managing money (like keeping track of expenses or paying bills)?	☐ Yes	☐ No
Do you need help shopping?	☐ Yes	☐ No
Do you need help with transportation?	☐ Yes	☐ No
Do you need help climbing a flight of stairs?	☐ Yes	☐ No

HOME SAFETY SCREEN

Do you have easy access to a phone at home?	☐ Yes	☐ No
Are emergency numbers easily accessible?	☐ Yes	☐ No
Do you have functioning smoke/carbon monoxide alarms in your home?	☐ Yes	☐ No
Do you have non-slip surface and grab bars in bath/shower?	☐ Yes	☐ No
If you climb stairs at home, are there secure railing?	☐ Yes	☐ No

NUTRITION

Number of servings of fruits do you have a day?
☐ 1-3 ☐ 4-7 ☐ 7-10 ☐ >10 ☐ NONE

Number of servings of vegetables do you have a day?
☐ 1-3 ☐ 4-7 ☐ 7-10 ☐ >10 ☐ NONE

ADVANCED CARE PLANNING

Do you wish to discuss end-of-life issues with the provider?	☐ Yes	☐ No

DEPRESSION SCREENING

PHQ-9
0-Not at all 1-Several days 2- More than half the days 3-Nearly everyday

Little interest or pleasure in doing things	___________
Feeling down, depressed, or hopeless	___________
Trouble falling or staying asleep, or sleeping too much	___________
Feeling tired or having little energy	___________
Poor appetite or overeating	___________

Feeling bad about yourself-or that you are a failure or have let yourself or your family down	___________
Trouble concentrating on things, such as reading the newspaper or watching television	___________
Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	___________
Thoughts that you would be better off dead, or of hurting yourself in some way?	___________

ALCOHOL SCREENING

Did you have a drink containing alcohol in the past year?	☐ Yes	☐ No
If yes, how often did you have a drink containing alcohol in the past year? ☐ monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times per week ☐ 4 or more times a week		
If yes, how many drinks did you have on a typical day when you were drinking in the past year? ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more		
If yes, how often did you have six or more drinks on one occasion in the past year? ☐ never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or almost daily		

EXERCISE

How many days a week do you exercise? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Duration: ☐ 30 minutes each time ☐ Less than 30 minutes each time ☐ more than 30 minutes each time		

TOBACCO SCREENING

Are you a? ☐ Non-smoker ☐ Former smoker ☐ Current daily smoker ☐ Current some day smoker ☐ Chewing tobacco user		
If **former smoker**, how long has it been since you last smoked? ☐ < 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 1-5 years ☐ 5-10 year ☐ >10 years		
If **current daily smoker**, how many cigarettes a day do you smoke? ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more		
If **current daily smoker**, how soon after you wake up do you smoke? ☐ within 5 min ☐ 6-30 min ☐ 31-60 min ☐ after 60 min		
If **current daily smoker**, are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit		

FALL RISK ASSESSMENT

Have you fallen in the past year?	☐ Yes	☐ No
If yes, how many times?	☐ 1	☐ >2
Were you injured?	☐ Yes	☐ No