



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 (*examples: cardiologist, pulmonologist, endocrinologist, urologist, nephrologist, rheumatologist, neurologist, podiatrist, eye specialist, dentist, oxygen supplier, home health agency or other specialist*)

Provider Name	Specialty

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

DEPRESSION SCREENING (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle your answer to each question)	Not at all	Several days	More than half the days	Nearly Every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself --- or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Scoring _____ + _____ + _____ + _____
= Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult
at all
☐

Somewhat
difficult
☐

Very
difficult
☐

Extremely
difficult
☐

TOBACCO SCREENING	
Are you a?	<input type="checkbox"/> Never smoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Current daily smoker <input type="checkbox"/> Current some day smoker <input type="checkbox"/> Chewing tobacco user <input type="checkbox"/> E-cigarette user <input type="checkbox"/> Vapor use
If former smoker , how long has it been since you last smoked?	<input type="checkbox"/> < 1 month <input type="checkbox"/> 1-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> 1-5 years <input type="checkbox"/> 5-10 years <input type="checkbox"/> 10-15 years <input type="checkbox"/> >15 years
How old were you when you started smoking?	
If current daily smoker , how many cigarettes per day?	<input type="checkbox"/> 5 or less <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-30 <input type="checkbox"/> 31 or more
If current daily smoker , how soon after you wake up do you smoke?	<input type="checkbox"/> within 5 min <input type="checkbox"/> 6-30 min <input type="checkbox"/> 31-60 min <input type="checkbox"/> after 60 min
If current daily smoker , are you interested in quitting?	<input type="checkbox"/> Ready to quit <input type="checkbox"/> Thinking about quitting <input type="checkbox"/> Not ready to quit

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

FUNCTION SCREEN		
Do you need helping feeding yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help getting from bed to chair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help getting to the toilet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help getting dressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help bathing or showering?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help walking across the room (includes using cane or walker)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help using the telephone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help taking your medicines?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help preparing meals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help managing money (like keeping track of expenses or paying bills)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help shopping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help with transportation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you need help climbing a flight of stairs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HOME SAFETY SCREEN		
Do you have easy access to a phone at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are emergency numbers easily accessible?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have functioning smoke/carbon monoxide alarms in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have non-slip surface and grab bars in bath/shower?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you climb stairs at home, are there secure railing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Office Use: Enter Mini-Cog Score in ECW

NUTRITION

Number of servings of fruits do you have a day?

☐ 1-3 ☐ 4-7 ☐ 8-10 ☐ >10 ☐ I do not eat Fruit

Number of servings of vegetables do you have a day?

☐ 1-3 ☐ 4-7 ☐ 8-10 ☐ >10 ☐ I do not eat Vegetables

ADVANCE CARE PLANNING

Do you wish to discuss your end-of-life medical treatment decisions and/or who you designate to make decisions for you if you are unable to speak for yourself?

☐ Yes ☐ No

OPIOID/NARCOTICS SCREENING

Have you used Opioid/Narcotics in the past 6 months? ☐ Yes ☐ No

If yes, how often?

☐ daily ☐ a few times a week ☐ a few times a month ☐ briefly after surgery ☐ briefly after injury

If yes, for what reason? _____

Have you used any other treatments? *(please select all that apply)*

☐ Ibuprofen/Naproxen ☐ Tylenol ☐ Exercise ☐ Stretches ☐ Cold/Warm packs ☐ Massage
☐ Chiropractor ☐ TENS unit ☐ Other *(please specify)* _____

Which provider(s) are managing your pain? ☐ Pain Management ☐ Orthopedics ☐ Primary Care Provider

☐ Other *(please specify)* _____

FALL RISK ASSESSMENT

Have you fallen in the past year? ☐ Yes ☐ No

If yes, how many times? ☐ 1 ☐ >2

Were you injured? ☐ Yes ☐ No

Do you use an assistive device such as a cane, walker, or wheelchair? ☐ Yes ☐ No

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