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 *(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? ☐ Never smoker ☐ Former smoker ☐ Current daily smoker ☐ Current some day smoker ☐ Chewing tobacco user ☐ E-cigarette user ☐ Vapor use
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 years ☐ 10-15 years ☐ >15 years
How old were you when you started smoking?
If **current daily smoker**, how many cigarettes per day? ☐ 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

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

*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