

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

TOBACCO SCREENING

Tobacco Use: Never Current, Daily Smoker Current, Some Days Smoker Former Smoker

If current or former, what tobacco products do you use? Cigarettes Cigars Pipe

If current or former cigarette smoker, how many per day? # of packs per day _____ OR # of cigarettes per day _____

If current or former cigarette smoker, date/year started smoking _____

If former cigarette smoker, date/year quit smoking _____

If current or former cigarette smoker, number of years smoked _____

If former cigarette smoker, how long has it been since you smoked? less than 15 yrs ago more than 15 years ago

If current daily smoker, are you interested in quitting? Ready to Quit Thinking About Quitting Not Ready to Quit

Do you use any of these nicotine products? E-Cigarettes Vaping Products Smokeless Tobacco Other: _____

If you use smokeless tobacco, what product?

chewing tobacco Snuff snus dissolvable tobacco Other: _____

Do you have exposure to second hand tobacco smoke? Yes No

SUBSTANCE 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

Do you take any opioid medications? Yes No

Non-prescribed substance use:

- Denies use Former substance abuser Cannabis / any form Crack / cocaine
 Amphetamines / methamphetamines Sedatives / tranquilizers Opioids / painkillers
 Club / designer drugs Over the counter / e.g. Imodium Decline to answer Other

SOCIAL SCREENING

In the past 12 months, how often did you fear food will run out before you are able to buy more

Often true Sometimes true Never true Decline to Answer

In the past 12 months, how often food did not last until there was money to buy more

Often true Sometimes true Never true Decline to Answer

Occupation: _____

Education level: Pre-School Grade School Home school High School College Other

Pets: None dog cat other _____

Marital status: Divorced Legally separated Life Partner Married Single Widow/Widower

Living arrangements: Alone Assisted Living Group Home Homeless Institution

Intermediate Care Facility Live-in Caregiver Senior House Significant Other

Skilled Nursing Facility With Children With Others With Parent With Spouse

Do you feel comfortable filling in medical forms? Yes No

HEALTH STATUS – SELF ASSESSMENT

Over the past four weeks, how would you rate your health? Excellent Good Fair Poor

HEALTH CONCERNS

Which (if any) of the following are problems for you:

- None I am tired or fatigued I experience a lot of stress or anger
 I am lonely or don't have a lot of support at home I have difficulty taking or remembering my medicines

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

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
NUTRITION		
Are you following a diet by a prescribed by a doctor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you following a special diet?	<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 have any problems with your teeth or dentures?	<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 have trouble with incontinence (leaking of urine)?	<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
Do you have any sexual problems you would like to discuss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FALL RISK ASSESSMENT

Have you experienced any balance or walking problems? Yes No

Have you fallen at all in the past year?

- No prior history of falls 1 fall in the past year 2+ falls in the past year
 Fall with injury in the past year Bedridden Other: _____

If yes, were you injured? Yes No

Assistive device used:

- Cane Walker Wheelchair Commode chair Hospital Bed Respiratory device

EXERCISE

On many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?

- 0 1 2 3 4 5 6 7

Duration: On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise? _____ minutes