Medicare Annual Wellness Visit Questionnaire

Name: ______________________________ **Date of Birth:** ___________ **Today's date:** _________

1. What Over the Counter medications are you taking, including vitamins and supplements?

Medication/Vitamin/Supplement:	Reason:

If you need more space, please write on back of page.

Please list any drug allergies:____

2. Have you ever or do your smoked? [ ] Yes [ ] No Quit?________________

3. Have you had any immunizations that were not given here in our office? [ ] Yes [ ] No

Which ones:	Who administered:

4. Have you had any hospitalizations, surgeries, major events happen since your last yearly exam?

What:	When and where:

5. Have any of your close relatives had any health changes?

Who:	Health change:

6. What other physicians or providers do you see, and for which problems?

Specialist:	Problem:

7. Where do you get your medical supplies? (Diabetes, ostomy supplies, CPAP, etc)

Medical Supplier:	What they supply:

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8. Have you had any preventative tests done recently?

Tests:	When and where was it performed:
Pap smear/pelvic exam:	
Colonoscopy:	
DEXA scan:	
Eye exam:	
Mammogram:	
PSA:	

Functional assessment:

9. Do you worry about falling: [ ] Yes [ ] No

10. Are you worried about your memory? [ ] Yes [ ] No

11 Has your mood changed? [ ] Yes [ ] No

12. Do you have an Advanced Directive? [ ] Yes [ ] No

13. Do you need help with the bathing, telephone use, transportation, shopping, preparing meals, housework, laundry, medications or managing money? [ ] Yes [ ] No
If yes, please circle ones you need help with.

14. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? [ ] Yes [ ] No
If yes, please circle ones you need help with.

15. Do you live alone? [ ] Yes [ ] No

16. Do you have trouble hearing the television or radio when others do not? [ ] Yes [ ] No

17. Do you have to strain or struggle to hear/understand conversations? [ ] Yes [ ] No

18. Does your home have a working smoke alarm? [ ] Yes [ ] No

19. Have you had a sleep study or been diagnosed with Sleep Apnea? [ ] Yes [ ] No

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Depression Questionnaire: **Over the last 2 weeks, how often have you been bothered by the following:**

	Not at all	Several days	More than half the time	Everyday
1. Little interest in doing things:	0	1	2	3
2. Feeling down or depressed:	0	1	2	3
3. Can't sleep or sleep too much:	0	1	2	3
4. Tired or having little energy:	0	1	2	3
5. Poor appetite or over-eating:	0	1	2	3
6. Feeling like a failure:	0	1	2	3
7. Trouble concentrating:	0	1	2	3
8. Moving slow or being fidgety:	0	1	2	3
9. Thinking that you would be better off dead or hurting yourself:	0	1	2	3
Totals:	0 +	____ +	____ +	____
		= Total score ___________		
10. Are you having difficulty working, taking care of your home, or getting along with other people?	Not at all	Some	Very difficult	Extremely difficult

Assessment of Suicidal Risk/Severity

1. Have you ever attempted to harm yourself in the past? [ ] Yes [ ] No
2. Have you currently thought about how you might actually hurt yourself? [ ] Yes [ ] No
3. Is there anything that would prevent you from harming yourself? [ ] Yes [ ] No
4. How likely are you to act on these thoughts? [ ] Not [ ] Possibly [ ] Probably

Comments:____

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