Patient Name: _____

MRN Number: _____

Date: _____

Hoag Medical Group • Mission Heritage Medical Group
St. Joseph Heritage Medical Group • St. Jude Heritage Medical Group
St. Mary High Desert Medical Group • St. Joseph Health Medical Group
In alliance with St. Joseph Heritage Healthcare

MEDICARE ANNUAL WELLNESS QUESTIONNAIRE

Please complete this checklist before seeing your doctor or nurse.
Your responses will help us provide the best care. We will also perform a vision test.

List of current providers you see: ☐ **NONE** ☐ **N/A**

1) Condition: _____
2) Condition: _____
3) Condition: _____
4) Condition: _____
5) Condition: _____

List of current medical equipment suppliers: (oxygen, CPAP, etc) ☐ **NONE** ☐ **N/A**

1) _____
2) _____
3) _____
4) _____
5) _____

List of current supplements including doses: ☐ **NONE** ☐ **N/A**

1) _____
2) _____
3) _____
4) _____
5) _____

General Health: Circle appropriate response

1. In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
2. Do you have dental problems that have not received proper attention? ☐ Yes ☐ No
3. Each night, how many hours of sleep do you usually get? _____ # of hours
4. Do you snore or has anyone told you that you snore? ☐ Yes ☐ No
5. Have you noticed difficulty with your hearing? ☐ Yes ☐ No
6. Do you have either of the following: ☐ Ringing in the ear ☐ Dizziness ☐ Discharge
7. Have you had a recent eye exam? ☐ Yes ☐ No

Eye Exam (Ophthalmologist) Provider Name: _____ Date of last eye exam: _____

Nutrition

8. In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? _____ # of servings per day
   (One serving=1 cup of fresh vegetables, ½ cup or cooked vegetables, or 1 med piece of fruit)
9. In the past 7 days, how many servings of fried or high fat foods did you typically eat each day? _____ # of servings per day
   (Examples include fried chicken or fish, bacon, french fries, potato chips, donuts, foods made with cream)
10. In the past 7 days, how many servings of sugar-sweetened (not diet) beverages did you typically consume each day? _____ # servings per day

Exercise

11. In the past 4 weeks, how many days did you exercise? _____ days
12. On days when you exercised, for how long did you exercise? _____ # of hours per day _____ # of minutes per day
13. How intense was your typical exercise?
    ☐ Light (like stretching or slow walking) ☐ Moderate (like brisk walking)
    ☐ Heavy (like jogging or swimming) ☐ Very heavy (like fast running or stair climbing)
    ☐ I am currently not exercising

Alcohol: In the past four weeks, on average how many drinks of wine, beer or other alcoholic beverages did you drink?
☐ None ☐ 1 or less ☐ 2-5 per week ☐ 6-9 per week ☐ 10 or more per week
How many times in the last year have you had 4 or more drinks in a day?
☐ Never ☐ A few times a year ☐ Monthly ☐ Weekly ☐ Daily or almost daily

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MEDICARE ANNUAL WELLNESS QUESTIONNAIRE

Tobacco: In the last 30 days, have you used tobacco? Smoked: ☐ Yes ☐ No Smokeless tobacco product: ☐ Yes ☐ No
Would you be interested in quitting tobacco use within the next month? ☐ Yes ☐ No

Depression

14. In the past 2 weeks, how often have you felt down, depressed, or hopeless?
☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never
15. In the past 2 weeks, how often have you felt little interest or pleasure in doing things?
☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never

Home Safety

16. Does your home have:

Rugs in the hallway?	☐ Yes	☐ No	Handrails on the stairs?	☐ Yes	☐ No
Grab bars in the bathroom?	☐ Yes	☐ No	Good lighting?	☐ Yes	☐ No

Activities of Daily Living

17. In the past 7 days, did you need help from others to perform everyday activities such as sitting, getting dressed, grooming, bathing, walking or using the toilet?
☐ Yes ☐ No If yes, which area (s): _____
18. In the past 7 days, did you need help from others to take care of such things as laundry, housekeeping, banking, shopping, food preparation, transportation or taking your medications?
☐ Yes ☐ No If yes, which area (s): _____
19. Do you need help writing checks or managing your finances? ☐ Yes ☐ No
20. Do you always fasten your seat belt when you are in a car? ☐ Yes ☐ No ☐ Sometimes
21. Have you fallen two or more times in the past year? ☐ Yes ☐ No
22. Do you have an advanced health directive or POLST? ☐ Yes ☐ No
a. If yes, has anything changed? ☐ Yes ☐ No
b. If no, would you like to receive more information? ☐ Yes ☐ No

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In addition to the no cost Medicare preventive exam, I would like the provider to address the following items, if there is time:
I understand that my regular personal copay, deductible and /or co-insurance will apply as the below is a separate, billable type of visit.
☐ Yes, please review information below. ☐ No, thank you, not at this time. I have no other concerns regarding my health.

Chronic conditions:

1) _____
2) _____
3) _____
4) _____
5) _____

Current medication refill requests:

1) _____
2) _____
3) _____
4) _____
5) _____

New Problems: Please include symptoms and duration

1) _____
2) _____
3) _____
4) _____

Please sign here acknowledging the above: (Patient, Legal Representative): _____Date:_____Time: _____
If signed by other than patient, indicate relationship:_____

Reviewed by (Provider): _____ Date: _____