

MEDICARE ANNUAL WELLNESS QUESTIONNAIRE

Patient Name: _____ MRN: _____ Date: _____

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

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

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

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

List of current supplements including doses: NONE N/A

1)	_____
2)	_____
3)	_____

4)	_____
5)	_____
6)	_____

General Health: Check 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 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, 1/2 cup of 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? _____ # of 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



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 seatbelt 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 advance 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

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: _____

Print Name (Legal Representative): _____

Reviewed by (Provider): _____ Date: _____ Time: _____