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	
Provider Name	**Specialty**

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 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 help 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
Do you have daily pain?	☐ Yes	☐ No
If Yes does it limit your activity?	☐ 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 railings?	☐ Yes	☐ No

NUTRITION

Number of servings of fruits do you have a day? ☐ 1-3 ☐ 4-7 ☐ 7-10 ☐ > 10 ☐ NONE
Number of servings of vegetables do you have a day? ☐ 1-3 ☐ 4-7 ☐ 7-10 ☐ > 10 ☐ NONE

ADVANCED CARE PLANNING

Do you wish to discuss end-of-life issues with the provider?	☐ Yes	☐ No

DEPRESSION SCREENING

PHQ-9 (In the last Two (2) weeks, have you felt any of the following… Please rate each one using the 0-3) **0** – Not at all **1** – Several days **2** – More than half the days **3** – Nearly every day	
Little interest or pleasure in doing things	_____
Feeling down, depressed, or hopeless	_____
Trouble falling or staying asleep, or sleeping too much	_____
Fatigue or Feeling Tired	
Poor appetite or overeating	_____
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	_____
Trouble concentrating on things, such as reading the newspaper or watching television	
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	_____
Thoughts that you would be better off dead, or of hurting yourself in some way?	_____
If you checked off any problems, how difficult have those 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	

ALCOHOL SCREENING

Have you had 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		

TOBACCO SCREENING

Please select one of the following options below, Are you a; ☐ Non-smoker ☐ Former smoker ☐ Current daily smoker ☐ Current some day smoker ☐ Chewing tobacco user
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 years
If **current daily smoker**, how many cigarettes a day do you smoke? ☐ 5 or less ☐ 6-30 ☐ 31-60 ☐ over 60
If **current daily smoker**, are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

FALL RISK ASSESSMENT

Have you fallen in the past year?	☐ Yes	☐ No
If yes, how many times?		
Were you injured?	☐ Yes	☐ No