



Name: _____ Date of birth: _____

Medicare Annual Wellness Visit

How have things been going for you in the past 4 wks?

- Very well , could hardly be better
- Pretty well
- Good and bad parts about equal
- Pretty bad
- Very bad, couldn't hardly be worse

How would you rate your physical health?

- Excellent
- Very good
- Good
- Fair
- Poor

How confident are you to manage your health?

- Very confident
- Somewhat confident
- Not very confident
- I do not have any health problems

Over the past 2 weeks, how often have you felt down, depressed or hopeless?

- Not at all
- Several days
- More than half the days
- Nearly every day

Over the past 2 weeks, how often have you felt little interest or pleasure in doing things you usually enjoy?

- Not at all
- Several days
- More than half the days
- Nearly every day

Do you feel safe from abuse in your home? YES / NO

Are you having trouble driving your car?

- Yes, often
- Sometimes
- No
- I do not drive a car

Do you always fasten your seat belt?

- Yes, usually
- Yes, sometimes
- No

Have you fallen in the past year? YES / NO

Are you afraid of falling? YES / NO

Do you use any of the following?

- Cane, wheelchair, walker
- Brace or prosthesis
- Hearing aid
- Dentures
- Glasses
- Raised toilet seat, bathtub bars, toilet bars
- Devices for dressing, eating or bathing
- Emergency alert system
- I do not use any assistive devices

Have you been given any information to help you with keeping track of your medications? YES / NO

How often do you have trouble taking your medications the way you have been told?

- I do not take medications
- I always take them as prescribed
- Sometimes I take them as prescribed
- I seldom take them as prescribed

Are you a smoker?

- No
- Yes, and I might quit
- Yes, but I'm not ready to quit

In the past 4 weeks, how many drinks of wine, beer alcoholic beverages have you had?

- 10 or more per week
- 6-9 per week
- 2-5 per week
- 1 or less per week

In the past 4 weeks, what was the hardest level of physical activity you have done?

- Very hard
- Hard
- Moderate
- Light
- Very light

Do you have a regular exercise program?

- Yes
- No

Do you exercise for at least 20 minute, 3 or more days a week?

- Yes, most of the time
- Yes, sometimes
- No, I usually do not exercise this much

Medicare Annual Wellness Visit continued

In the past 4 weeks, has your physical or emotional health limited your social activities with family, friends, neighbors or groups?

- Not at all
- Slightly
- Moderately
- Quite a bit

Do you need help with any of the following:

- Getting places outside of walking distance without help
- Shopping for groceries or clothes
- Preparing your own meals
- Housework
- Handling your own money
- Personal care needs
- I do not need help around the house

In the past 4 weeks, have you been bothered by any of the following?

- Dizzy when standing up
- Trouble eating well
- Teeth or denture problems
- Tiredness or fatigue
- Trouble seeing
- Foot problems
- Trouble thinking or remembering
- Trouble sleeping
- I am not bothered by any of these problems

Do you have difficulty hearing the TV or radio when others do not? YES / NO

Do you have to strain or struggle to hear or understand conversations? YES / NO

In the past 6 months, have you experienced urinary leakage, sometimes called bladder control problems? YES / NO

If you became too sick to speak for yourself, who would decide about medical treatment for you?

- Family member
- Friend
- My doctor
- Other
- I am not sure

Have you completed an advanced directive? YES / NO

Have you completed a POLST? (physician's orders for life-sustaining treatment) YES / NO

Thank you for taking the time to complete this form. It will enable us to more effectively help you at your upcoming visit with us. Please see below for a list of what you need to bring with you to your appointment.

- Full list of medications you are taking
- Full list of doctors involved in your care
- This completed form to give to the Medical Assistant when you arrive