Medicare Annual Wellness Visit Questionnaire

NAME:_____Date of Birth:_____ Date of Exam:_____

Hearing Loss Screening		
Do you have trouble hearing the TV or Radio?	☐ Yes	☐ No
Do you have trouble understanding conversations?	☐ Yes	☐ No

Function/Fall Risk Screening		
Do you need help from others to perform daily activities such as eating, getting dressed, and using the bathroom?	☐ Yes	☐ No
Do you handle your own medications?	☐ Yes	☐ No
Do you handle you own finances?	☐ Yes	☐ No
Do you live alone?	☐ Yes	☐ No

Visual Screening		
In the past year, have you seen an eye doctor?	☐ Yes	☐ No
Do you have trouble seeing, even with glasses?	☐ Yes	☐ No

Safety Screening		
Do you have throw rugs?	☐ Yes	☐ No
Do you have low/poor lighting?	☐ Yes	☐ No
Does your bathroom have grab bars?	☐ Yes	☐ No
Do your stairs have handrails?	☐ Yes	☐ No
Do you have functioning smoke alarms?	☐ Yes	☐ No

List Of Providers

Provider Name	**Specialty**

Advance Care Plan		
Do you have an Advanced Directive?	☐ Yes	☐ No

Depression Questionnaire

Over the last 2 weeks, have you:

Felt down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐ More than 1/2 the day ☐ Nearly everyday

Had little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than 1/2 the day ☐ Nearly everyday

Preventative Screening

When was your last colonoscopy or cologuard? _____

When was your last mammogram? _____

When was your last bone density? _____

Behavioral Risks

Have you recently used tobacco? ☐ Yes ☐ No

Number of packs per day: _____

Number of years smoking: _____

How often do you have alcohol during the week?

☐ Never ☐ Once ☐ 2-3 times ☐ 3 or more times

Have you seen a dentist within the last year? ☐ Yes ☐ No

Do you have any concerns with your diet? ☐ Yes ☐ No

Do you always fasten your seat belt when you are in a car? ☐ Yes ☐ No

General Health

In the last 7 days, have you felt any unusual pain or fatigue? ☐ Yes ☐ No

Are you experiencing any bladder or bowel problems ☐ Yes ☐ No

Do you have any concerns regarding your sexual health that you would like to discuss with your provider? ☐ Yes ☐ No

In the last 7 days, how often have you exercised _____

Have you experienced any falls since your last visit? ☐ Yes ☐ No

In general, how would you say your health is?

☐ Excellent ☐ Good ☐ Fair ☐ Poor