



# Medicare Annual Wellness Visit Questionnaire

PATIENT DEMOGRAPHICS

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
LAST FIRST MIDDLE MM/DD/CCYY

Home Address: \_\_\_\_\_  
STREET APT/UNIT CITY STATE ZIP

Gender:  Female  Male

Home Phone: \_\_\_\_\_ Day Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

SS #: \_\_\_\_\_

Next of Kin (for emergency): \_\_\_\_\_

Name of spouse : \_\_\_\_\_ Day Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

Insurance: Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Policy# Group # \_\_\_\_\_

CURRENT MEDICAL PROBLEMS

**List any current medical problems or conditions.**

1) _____	7) _____
2) _____	8) _____
3) _____	9) _____
4) _____	10) _____
5) _____	11) _____
6) _____	12) _____

PAST MEDICAL HISTORY

**Childhood Illnesses**

1) _____	3) _____	5) _____
2) _____	4) _____	6) _____

**Chronic Illnesses**

1) _____	3) _____	5) _____
2) _____	4) _____	6) _____

**Last Eye/Glaucoma Exam:** \_\_\_\_\_

**Past surgeries**

	Surgery	Date	Surgery	Date
1)	_____	_____	4)	_____
2)	_____	_____	5)	_____

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PAST MEDICAL HISTORY CONT'D	<b>List any other hospital stays</b>			
	Reason		Date	
	Reason		Date	
	1) _____	_____	4) _____	_____
	2) _____	_____	5) _____	_____
	3) _____	_____	6) _____	_____
	<b>Physicians/practitioners you currently see</b>			
	Name / Specialty		Name / Specialty	
	1) _____	_____	4) _____	_____
	2) _____	_____	5) _____	_____

ALLERGIES	<b>List any allergies to medication, x-ray dyes, or food.</b>	
	<b>Allergy</b>	<b>Reaction</b>
	_____	_____
	_____	_____

MEDICATIONS	<b>List any medication that you currently take, including over-the-counter.</b>			
	Name	Strength	Direction	Prescribed by
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

SOCIAL HISTORY	Do you drink alcohol?..... <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes how much?</i> _____
	Are others concerned about your drinking? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Diet: <input type="checkbox"/> Balanced <input type="checkbox"/> Vegetarian <input type="checkbox"/> Diabetic <input type="checkbox"/> Low salt <input type="checkbox"/> Low fat <input type="checkbox"/> Low carb <input type="checkbox"/> Other: _____
	Education: <input type="checkbox"/> High school <input type="checkbox"/> College <input type="checkbox"/> Some College <input type="checkbox"/> Trade school <input type="checkbox"/> Other: _____
	Do you do some form of regular exercise every day? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, how much?</i> _____
	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____
	Occupation: _____
	List everyone in your household including pets: _____ _____
	Do you wear seatbelts? ..... <input type="checkbox"/> No <input type="checkbox"/> Yes
	Have you ever smoked or chewed tobacco? ..... <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, how much?</i> _____

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**ROUTINE TASKS: Please indicate if you do or do not need help performing these routine tasks**

SOCIAL HISTORY CONT'D

- |  |  |                          |
|--|--|--------------------------|
| 1) Feeding yourself  | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 2) Getting from bed to chair   | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 3) Getting to the toilet   | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 4) Getting dressed   | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 5) Bathing or showering  | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 6) Walking across the room<br>(includes using cane or walker)          | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 7) Using the telephone   | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 8) Taking your medicines   | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 9) Preparing meals   | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 10) Managing money<br>(like keeping track of expenses or paying bills) | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 11) Moderately strenuous housework such<br>as doing the laundry        | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 12) Shopping for personal items like toiletries<br>or medicines        | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 13) Shopping for groceries   | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 14) Driving  | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |
| 15) Climbing a flight of stairs  | <input type="checkbox"/> No <input type="checkbox"/> Yes | If yes, who helps? _____ |

**Please list any health problems and causes of death if applicable.**

FAMILY HISTORY

	Living / Deceased	Age	Medical Problems
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
	_____	_____	_____
Sister(s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Mother's father	_____	_____	_____
Mother's mother	_____	_____	_____
Father's father	_____	_____	_____
Father's mother	_____	_____	_____

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

***Please record the last year you had the following. If you do not know, leave blank.***

HEALTH MAINTENANCE

- |  |                           |
|--|---------------------------|
| HepB (shot) .....                      | Hearing Exam .....        |
| Flu vaccine (shot) .....               | Hemocult.....             |
| Pneumonia vaccine (shot) .....         | Lipid Panel .....         |
| Tetanus Diphtheria vaccine (shot)..... | Mammogram.....            |
| Zostavax (shot) .....                  | Nutritional Therapy ..... |
| Abdom. Aortic Aneurysm Screening....   | Pap Smear.....            |
| Bone Density Scan .....                | Pelvic Exam.....          |
| Colonoscopy.....                       | Prostate Exam.....        |
| Diabetes Self Management Training....  | PSA Test.....             |
| Echocardiogram.....                    | Rectal Exam .....         |
| Eye Glaucoma Exam .....                | Smoking Cessation.....    |
| Glucose.....                           |                           |

**HEARING: Check NO, YES, or SOME TIMES for each question.**

HEARING

- 1) Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?.....  No  Yes  Sometimes
- 2) Do you sometimes feel that people are mumbling or not speaking clearly? .....  No  Yes  Sometimes
- 3) Do you experience difficulty following dialogue in the theater?.....  No  Yes  Sometimes
- 4) Do you sometimes find it difficult to understand a speaker at a public meeting or religious service? .....  No  Yes  Sometimes
- 5) Do you find yourself asking people to speak up or repeat themselves?.....  No  Yes  Sometimes
- 6) Do you find men’s voices easier to understand than women’s? .....  No  Yes  Sometimes
- 7) Do you experience difficulty understanding soft or whispered speech?.....  No  Yes  Sometimes
- 8) Do you sometimes have difficulty understanding speech on the telephone?.....  No  Yes  Sometimes
- 9) Does a hearing problem cause you to feel embarrassed when meeting new people?.....  No  Yes  Sometimes
- 10) Do you feel handicapped by a hearing problem?.....  No  Yes  Sometimes
- 11) Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like? .....  No  Yes  Sometimes
- 12) Do you experience ringing or noises in your ears? .....  No  Yes  Sometimes
- 13) Do you hear better with one ear than the other? .....  No  Yes  Sometimes
- 14) Have you had any significant noise exposure during work, recreation, or military service? .....  No  Yes  Sometimes
- 15) Have any of your relatives (by birth) had a hearing loss? .....  No  Yes  Sometimes

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

DEPRESSION SCREENING

Please write your answer in the space provided.

- 1) Little interest or pleasure in doing things. \_\_\_\_\_
- 2) Feeling down, depressed, or hopeless \_\_\_\_\_

Key:

**0**-Not at all    **1**-Several days    **2**-More than half the days    **3**-Nearly everyday

FALL RISK SCREENING

Please check the appropriate answer.

- 1) Are you afraid of falling?                     No     Yes
- 2) Have you fallen in the past year?                     No     Yes
- 3) If yes, circle the circumstances surrounding the fall.

Answers:

- Tripped over something*
- Lightheadedness or palpitations prior to*
- Loss of consciousness*
- Injured*
- Needed to see a doctor*
- Able to get up on own*

ADVANCE DIRECTIVE

Do you have an Advanced Directive (living will)?  No  Yes

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_