Medicare Annual Wellness Visit Questionnaire

Name: ______________________________ **Date of Birth:** _______________**Today's Date:** ______________

What over the Counter Medications are you taking, including vitamins and supplements?

Medications/Vitamins/Supplement	Reason

What other physicians or providers do you see, and for which problems?

Specialist	Problem

Where do you get your medical supplies? (Diabetes, ostomy supplies, etc)

Medical Supplier	Problem

How do you rate your health? (Circle one) Excellent Good Fair Poor

Hearing/Vision Evaluation:

Do you have trouble hearing the television or radio when others do not?	Yes	No
Do you have to strain or struggle to hear or understand conversations?	Yes	No
Do you have trouble seeing, even with glasses?	Yes	No

Functional Evaluation:

Do you have trouble walking?	Yes	No	Do you need help with shopping?	Yes	No
Do you need help climbing stairs?	Yes	No	Do you need help with preparing meals?	Yes	No
Do you need help with bathing?	Yes	No	Do you need help with housework?	Yes	No
Do you need help with dressing?	Yes	No	Do you need help with laundry?	Yes	No
Do you need help with telephone use?	Yes	No	Do you need help with taking medications?	Yes	No
Do you need help with transportation?	Yes	No	Do you need help with managing money?	Yes	No
Do you have trouble concentrating, remembering or making decisions?				Yes	No

Depression Questionnaire:

Over the past 2 weeks, have you felt down, depressed or hopeless?	Yes	No
Over the past 2 weeks, have you felt little interest or pleasure in doing things?	Yes	No

Home Safety:

Do you have a working smoke alarm in your home?	Yes	No
Does your home have loose rugs in the hallway?	Yes	No
Does your home have poor lighting?	Yes	No
Does your home have grab bars in the bathroom?	Yes	No
Does your home have handrails on the stairs?	Yes	No
Do you live alone?	Yes	No
In the past 12 months, have you fallen?	Yes	No
In the past 6 months, have you experienced leaking of urine?	Yes	No

Advance Directive:

Do you have an Advance Directive?	Yes	No