Medicare Annual Wellness Visit Questionnaire

Sutter Health

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 (Check 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 climbing stairs?	☐ Yes	☐ No
Do you need help with bathing?	☐ Yes	☐ No
Do you need help with dressing?	☐ Yes	☐ No
Do you need help with telephone use?	☐ Yes	☐ No
Do you need help with transportation?	☐ Yes	☐ No
Do you need help with shopping?	☐ Yes	☐ No
Do you need help with preparing meals?	☐ Yes	☐ No
Do you need help with housework?	☐ Yes	☐ No
Do you need help with laundry?	☐ Yes	☐ No
Do you need help with taking medications?	☐ 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 last 2 weeks have you:

Felt down, depressed, or hopeless?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
Had little interest or pleasure in doing things?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day

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

Additional Questions

Have you felt unusual pain or fatigue in the last 14 days?	☐ Yes	☐ No
Have you felt unusual stress, anger, or loneliness in the last 14 days?	☐ Yes	☐ No
Do you use seatbelts?	☐ Yes	☐ No
Do you have questions about your diet?	☐ Yes	☐ No
Have you seen your dentist within the last year?	☐ Yes	☐ No
Do you exercise at least 3 times a week?	☐ Yes	☐ No