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Medicare Annual Wellness Visit Questionnaire

Please complete this questionnaire and bring it with you to your next primary care appointment.

Patient Demographics

Date: _____/_____/_____

Name (first, last, middle): _____

Date of Birth: _____/_____/_____ Gender: _____ Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) - _____ - _____ Cell Phone: (_____) - _____ - _____

Emergency Contact Name: _____

Emergency Contact Phone: (_____) - _____ - _____

TO BE COMPLETED DURING OFFICE VISIT:

WEIGHT: _____ HEIGHT: _____ BMI: _____ BP: _____

Current Medical Problems

(Patient to list medical problems)

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Past Medical History

(Hospitalizations, Surgeries, Other Conditions)

Family Medical History

List all relatives diagnosed with any of the following conditions including their age at onset and please note if deceased.

- Heart Disease
- Diabetes
- Cancer/ Type
- Hypertension
- Mental Health/Depression
- Other: _____

Relative Type	Medical History	Deceased (Y/N)

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Other Healthcare Providers You See On A Regular Basis

Provider Name: _____

Reason for Visits: _____

Last Visit Date: _____/_____/_____ Next Visit Date: _____/_____/_____

Provider Name: _____

Reason for Visits: _____

Last Visit Date: _____/_____/_____ Next Visit Date: _____/_____/_____

Provider Name: _____

Reason for Visits: _____

Last Visit Date: _____/_____/_____ Next Visit Date: _____/_____/_____

Provider Name: _____

Reason for Visits: _____

Last Visit Date: _____/_____/_____ Next Visit Date: _____/_____/_____

Provider Name: _____

Reason for Visits: _____

Last Visit Date: _____/_____/_____ Next Visit Date: _____/_____/_____

Allergies

Allergy	Reaction

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Current Medications (please include OTC and supplements)

Name	Strength	Direction	Prescribed By

Detection of Cognitive Impairment

Are you worried about your memory? Yes ☐ No ☐

How often has confusion or memory loss interfered with your ability to work, volunteer or engage in social activities?

Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐

During the past 30 days how often has a family member or friend provided care or assistance for you because of confusion or memory loss?

Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never ☐

Functional Status

Do you have difficulty getting out of a chair or car without assistance?

Yes ☐ No ☐

Do you use a cane or walker? Yes ☐ No ☐

Do you notice any trouble hearing? Yes ☐ No ☐

Do you have problems with vision? Yes ☐ No ☐

Falls Risk Screening

In the last 12 months have you fallen? Yes ☐ No ☐

If yes, how many times? _____

Were you injured as a result of a fall? Yes ☐ No ☐

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Tobacco Product Use

Select One: None ☐ Current Use ☐ Past Use ☐

Type of Product: Smoke ☐ Smokeless ☐

How much per day? _____

How long? _____

Are you willing to quit? Yes ☐ No ☐

Screenings and Immunizations *(if unknown, please leave blank)*

Screenings (date of last)

Mammogram: _____/_____/_____

Colonoscopy: _____/_____/_____

Hemoccult (Stool Card): _____/_____/_____

Abdominal Aortic Aneurysm (males who ever smoked only): _____/_____/_____

Immunizations (date of last)

Flu Shot: _____/_____/_____

Pneumonia Vaccine:_____/_____/_____

Tetanus: _____/_____/_____

Shingles Vaccine: _____/_____/_____

PSA: _____/_____/_____

Depression Screening

Over the past two weeks, how often have you been bothered by any of the following problems?

1) Little interest or pleasure in doing things? Yes ☐ No ☐
2) Feeling down, depressed or hopeless? Yes ☐ No ☐

Advance Directive

Do you have an advanced directive (living will)? Yes ☐ No ☐

If yes, please bring a copy with you for your medical records.