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Date: _____/_____/_____

Medicare Annual Wellness Visit Questionnaire

Please complete this form and bring it with you to your Medicare Wellness visit (completion of this form by you is required by Medicare in order to qualify for the free Medicare Annual Wellness Visit).

Patient Demographics

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: (_____) - _____ - _____

Current Medical Problems (Please list your current medical problems)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Past Medical History

(Please list any hospitalizations, surgeries or other medical problems)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

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 ☐

Tobacco Product Use

Have you ever smoked?: Currently smoke ☐ Never smoked ☐ Former smoker ☐ Quit date:____

Type of Tobacco Product: Cigarettes ☐ Cigars ☐ Snuff / chewing tobacco ☐ eCig or vaping ☐

How much per day? _____

How long? _____

Are you willing to quit? Yes ☐ No ☐

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.

Screenings and Immunizations

(please fill in any screenings or immunizations that you may have had done outside of our office by another provider such as a gynecologist, a previous medical provider or at a pharmacy)

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: _____/_____/_____

Other Healthcare Providers You See on a Regular Basis

Provider Name:_____

Reason for visits:_____

Date of last visit: _____/_____/_____ Date of next visit: _____/_____/_____

Provider Name:_____

Reason for visits:_____

Date of last visit: _____/_____/_____ Date of next visit: _____/_____/_____

Provider Name:_____

Reason for visits:_____

Date of last visit: _____/_____/_____ Date of next visit: _____/_____/_____

Current Medications

(Please bring the bottles of your current medications and supplements to your visit **OR** list them below with the dose and how often you take them)

Medication name	Dose	How often take: