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

## Medicare Subsequent 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, middle, last): \_\_\_\_\_

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

### Medical History

(Please list any **NEW** medical problems, hospitalizations or emergency room visits in the past year)

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Do you see any other Healthcare Providers on a Regular Basis? Yes  No

If yes, please list other providers: \_\_\_\_\_

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### Advance Directive

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

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

### 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 Product: Cigarettes  Cigars  Snuff or 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

## 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

PSA: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hemoccult (Stool Card): \_\_\_\_/\_\_\_\_/\_\_\_\_

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

### Immunizations (date of last)

Flu Shot: \_\_\_\_/\_\_\_\_/\_\_\_\_

Pneumonia Vaccine: \_\_\_\_/\_\_\_\_/\_\_\_\_

Tetanus: \_\_\_\_/\_\_\_\_/\_\_\_\_

Shingles Vaccine: \_\_\_\_/\_\_\_\_/\_\_\_\_

