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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, middle, last): _____

Date of Birth: ____/____/____

Medical History

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

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

If yes, please list other providers: _____

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: ____/____/____

