MEDICARE ANNUAL WELLNESS VISIT (AWV)

Name: _____DOB: _____ Date**:** _____

Has anything changed in regard to your health in the past year? *(new illness, surgeries, new medication allergies or intolerances, etc.)*

Have there been any significant changes in your life in the past year such as i*ncreased stress, new job, home, relationship, children, ill relatives, etc.?*

Have any of your blood relatives developed any new illnesses in the past year? If any blood relative has had cancer, please list their relation to you, what they had, and how old they were when diagnosed:

If you have had any vaccines in the past year, please list them & the approximate date(s): _____

What is (or was) your occupation: _____ Spouse's occupation:_____
If you are retired, what year did you retire? _____
If you have children, what are their names & ages? _____
Do you currently use tobacco? ❑Yes ❑No What kind(s)? ❑Cigarettes ❑Cigars ❑Pipe ❑Vape ❑Chew
If yes, how much do you smoke (use) daily? _____
If no, have you ever used tobacco? ❑Yes ❑No What kind(s)? ❑Cigarettes ❑Cigars ❑Pipe ❑Vape ❑Chew
If yes, how many packs per day did you smoke? _____ How many years did you smoke? _____ Year Quit_____
Any exposure to secondhand smoke (others smoking around you) currently or in the past? ❑Yes ❑ No
If yes, please explain: _____
Do you currently use recreational drugs (like marijuana, etc)? ❑Yes ❑ No
Do you wear a seatbelt? ❑Yes ❑No ❑Occasionally
Do you exercise regularly? ❑Yes ❑ No If yes, what do you do for exercise and how often? _____
Please describe your diet _____
Have you had a new sexual partner in the past year? ❑Yes ❑ No Would you like to be tested for HIV or other STDs? ❑Yes ❑ No
Do you have any difficulties with hearing that limits your personal life? ❑Yes ❑No
Do you see a dentist at least once a year? ❑Yes ❑ No
During the past 4 weeks, how would you rate your health? ❑Excellent ❑Very Good ❑Good ❑Fair ❑Poor
Do you have any difficulties driving your own car or getting transportation if you do not drive? ❑Yes ❑No
During the past 4 weeks, was someone available to help you if you needed and wanted help? ❑Yes ❑No
Have you fallen 2 or more times in **the past year**? ❑Yes ❑No Are you afraid of falling? ❑Yes ❑No
Are you able to handle the following activities without help?

Shopping for groceries or clothes :	❑Yes ❑No	Preparing your own meals:	❑Yes ❑No
Doing housework:	❑Yes ❑No	Handling your money:	❑Yes ❑No
Keeping track of medications:	❑Yes ❑No	Bathing or dressing:	❑Yes ❑No

HEALTHCARE WISHES:

Do you already have a healthcare proxy or living will? ❑Yes ❑No Are you willing to be an organ donor? ❑Yes ❑No
Most healthy patients would like to be treated aggressively (CPR, respirator, ICU, etc) if they had a potentially curable condition. If you had a condition that had no chance of recovery, would you wish to remain on life support? ❑Yes ❑ No ❑Not Sure
If you were unable to make your own healthcare decisions *(for instance, you were in a coma from a car accident)*, whom would you like us to ask about what your wishes would be? Please name one person and one alternate.
Name: _____Phone #: _____Relationship to You: _____
Name: _____Phone #: _____Relationship to You: _____

Please list any other physicians you are currently seeing:

Name of Physician	**Location**	**Reason**

NAME: _____ **DATE:** _____

ANNUAL HEALTH SCREENINGS:

PHQ-9 **Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?** ***(Please ✓ the appropriate box)***	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				
If you checked off <u>any</u> problems listed above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? *(Please **circle** your answer)*	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

S: _____ Dx: _____

AUDIT-C Please **circle** your answers:	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times a month	2 - 3 times a week	4 or more times a week
How many standard drinks containing alcohol do you have on a typical day when you drink?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

S: _____ Dx: _____