**Annual Wellness Visit**

Medicare covers an Annual Wellness Visit (AWV) providing Personalized Prevention Plan Services (PPPS) at no cost to the beneficiary, so beneficiaries can work with their providers to develop and update a personalized prevention plan. This **new benefit** will provide an ongoing focus on prevention that can be adapted as a beneficiary’s health needs change over time. The first year, we will gather all essential information through your Annual Well Visit. Following your AWV, we will provide Subsequent Wellness Visits (SWV) to continue your PPPS, medical history, medical care, impairments, risk factors and intervention.

Please complete the following questionnaire **before** meeting with your provider. Your provider will use this information to create a wellness plan for you. Please answer all questions to the best of your ability.

**DEMOGRAPHICS**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your Age: □ Under 65 □ 65-69 □ 70-79 □ 80 or older?

Are you: □ Male □ Female

What is your race? (**Check all that apply**)

□ White

□ Black or African American

□ Asian

□ Native Hawaiian or Other Pacific Islander

□ American Indian or Alaskan Native

□ Hispanic or Latino origin or descent

□ Other

**BEHAVIORAL RISK FACTORS**

1. **PHYSICAL ACTIVITY/EXERCISE**

How many days per week do you exercise?

\_\_\_\_\_\_\_\_ Per week \_\_\_\_\_\_\_\_\_ minutes/day \_\_\_\_\_\_\_\_ I do not exercise (go to section B)

How would you rate the intensity level of your exercise program?

\_\_\_\_\_ Light (ex., slow walk, stretching) \_\_\_\_\_ Moderate (ex., brisk walking, golfing, bowling)

\_\_\_\_\_ Vigorous (ex., jogging, swimming, biking, heavy lifting)

In the **past four weeks,** have you been bothered by any of the following problems

 □ Falling or Dizzy

 □ Sexual Problems

 □ Trouble Eating

 □ Teeth or Denture Problems

 □ Using the Telephone

 □ Tiredness or Fatigue

During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

□ Very heavy

 □ Heavy

 □ Moderate

 □ Light

 □ Very Light

During the **past four weeks,** how much bodily pain have you generally had?

□ No pain

 □ Very mild pain

 □ Mild pain

 □ Moderate pain

**1**

On a typical day, how many hours of sleep do you usually get?

\_\_\_\_\_ hours per day

During the **past four weeks**, how would you rate your health in general?

□ Excellent

 □ Very Good

 □ Good

 □ Fair

 □ Poor

1. **SMOKING/TOBACCO USE**

Do you currently smoke cigarettes or cigars or use any other type of tobacco product?

\_\_\_\_\_Yes

\_\_\_\_\_Yes and I might quit

\_\_\_\_\_Yes, but I’m not ready to quit

\_\_\_\_\_ No

Are you a former smoker or have you used any other type of tobacco product?

\_\_\_\_\_ Yes, smoker \_\_\_\_\_Yes, other type of tobacco product

How long ago did you quit?

\_\_\_\_\_ Months

\_\_\_\_\_ Years

1. **ALCOHOL USE**

During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

 □ 10 or more drinks per week

 □ 6-9 drinks per week

 □ 2-5 drinks per week

 □ One drink or less per week

 □ No alcohol at all

1. **NUTRITION/DIET**

On a typical day, how many servings of fruits and vegetables do you consume?

\_\_\_\_\_\_\_\_ Servings per day

In a typical week, how many servings of fried or high in fat (such as cheese, fatty meat) do you consume?

\_\_\_\_\_\_\_\_ Servings per week

In a typical week, how many servings of high fiber or whole grain foods do you consume?

\_\_\_\_\_\_\_\_ Servings per week

How confident are you that you can control and manage most of your health problems?

 □ Very Confident

 □ Somewhat Confident

 □ Not Very Confident

□ I do not have any health problems

1. **MOTOR VEHICLE SAFETY**

Do you wear your seat belt when in the car?

 □ Yes □ No

Are you having difficulties driving your car?

 □ Yes, often

 □ Sometimes

 □ No

□ Not applicable, I don’t use a car

Can you get to places out of walking distance without help? (Example, can you travel alone on buses, taxis, or drive your own car)

 □ Yes □ No

**2**

1. **HOME SAFETY**

Do you have smoke detectors in your home and routinely change the batteries?

 □ Yes □ No

Do you have a fire extinguisher and know how to use it properly?

 □ Yes □ No

Have you been given any information to help you with the following?

 Hazards in your house that might hurt you?

 □ Yes □ No

1. **ACTIVITIES OF DAILY LIVING**

During the **past four weeks,** was someone available to help you if you needed and wanted help?

(Example, if you felt nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; help with daily chores; or needed help just taking care of yourself)

 □ Yes, as much as I wanted

 □ Yes, quite a bit

 □ Yes, some

 □ Yes, a little

 □ No, not at all

Do you need assistance with any of the following? Check all that apply.

\_\_\_\_\_Dressing

\_\_\_\_\_ Prepare Meals

\_\_\_\_\_ Using the restroom

\_\_\_\_\_ Bathing

\_\_\_\_\_ Walking

\_\_\_\_\_ Shopping

\_\_\_\_\_ Food Preparation

\_\_\_\_\_ Housekeeping

\_\_\_\_\_ Driving

\_\_\_\_\_ Organizing daily

medications

\_\_\_\_\_ Handling Finances

1. **FALL RISK**

Do you have any of the following in your home?

\_\_\_\_\_ Stairs

\_\_\_\_\_ Throw rugs

\_\_\_\_\_ Pets

\_\_\_\_\_ Damaged flooring

Have you fallen two or more times in the **past year?**

 **□** Yes **□** No

Are you afraid of falling?

 □ Yes □ No

**GENERAL HEALTH**

1. **SUN EXPOSURE**

Do you protect yourself from over exposure to the sun when outdoors?

 □ Yes □ No

1. **HEIGHT/WEIGHT**

What is your height? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ in. What is your weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ lbs.

At your last physician visit, how would you rate your blood pressure?

\_\_\_\_\_ Low to Normal

\_\_\_\_\_ Borderline High

\_\_\_\_\_ High

\_\_\_\_\_ Do not know

\_\_\_\_\_ I have not had my blood pressure taken for some time

At your last physician visit, how was your cholesterol reading, if done?

\_\_\_\_\_ Normal, Below 200

\_\_\_\_\_ Borderline, Between 200-239

\_\_\_\_\_ High, 240 or higher

\_\_\_\_\_ Do not know/not sure

\_\_\_\_\_ I have not had my cholesterol checked in the past year

**3**

At your last physician visit, how was your blood glucose (sugar) reading?

\_\_\_\_\_ Normal, Below 100

\_\_\_\_\_ Borderline, Between 100-125

\_\_\_\_\_ High, 126 or higher

\_\_\_\_\_ Do not know/not sure

\_\_\_\_\_ I have not had my blood glucose (sugar) checked in the past year

Do you suffer from chronic pain on a daily basis?

 □ Yes □ No

1. **Medications**

How often do you have trouble taking medicines the way you have been told to take them?

□ I do not have to take medicine

□ I always take them as prescribed

□ Sometimes I take them as prescribed

□ I seldom take them as prescribed

Have you been given any information to help you keep track of your medicines?

 □ Yes □ No

Please list current prescriptions and non-prescription medicines, vitamins, home remedies, herbs:

Medication/Vitamin/Herb Date Last Filled

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **PERSONAL / FAMILY HISTORY**

Please indicate whether you or a person related by blood has had any of the following medical problems

□ High Blood Pressure Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Stroke Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Heart Disease Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ High Cholesterol Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Diabetes Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Congestive Heart Failure Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Heart Attack Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Glaucoma Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Cancer Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Alcoholism Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Asthma/COPD Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Depression/suicide Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Thyroid Problems Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4**

1. **OTHER MEDICAL CARE**

List any other providers who provided medical care or treatment in the last 6 months:

**Name Date Condition** Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **MENTAL WELLNESS**

During the **past four weeks,** how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

□ Not at all

 □ Slightly

 □ Moderately

 □ Quite a bit

 □ Extremely

During the **past four weeks,** has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

□ Not at all

 □ Slightly

 □ Moderately

 □ Quite a bit

 □ Extremely

1. **THINKING ABILITY CHANGES**

I have noticed a recent decline in my memory. □ Yes □ No

Others (my friends or family) tell me that I am forgetting things they tell me. □ Yes □ No

My ability to concentrate seems to have declined recently. □ Yes □ No

I have suffered recent losses that might hurt some of my thinking abilities. □ Yes □ No

I get confused or easily distracted more than I used to. □ Yes □ No

 **P. LEG/FEET SYMPTOMS**

My leg(s) hurt when I walk long distance. □ Yes □ No

I get cramps in my legs when watching television or sitting still awhile. □ Yes □ No

I notice that my feet get cold or numb when I sit still for a time. □ Yes □ No

Occasionally I get a tingling in my legs or my hands. □ Yes □ No

The sores or wounds on my legs or feet seem to take a long time to heal. □ Yes □ No

1. **GASTRO & AUTONOMIC**

Heartburn or Indigestion seems to be a problem now and then. □ Yes □ No

I get frequent flatulence or abdominal gas discomfort on a regular basis. □ Yes □ No

I experience abdominal pain, gas or diarrhea after consuming milk products. □ Yes □ No

I occasionally have trouble with insomnia or falling asleep. □ Yes □ No

Fatigue and Drowsiness seem to be a common problem for me. □ Yes □ No

I often get a little lightheaded when I stand quickly after sitting awhile. □ Yes □ No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

**5**

TO BE COMPLETED BY PROVIDER



**COGNITIVE TESTING (Effective 01/1/18)**

Cognitrax Computerized Testing: □ 96103 AND □ 96120

CNS-VS – Cognitive Assessment & Care Planning □ 99483

Covered Medicare Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No Impairment □ Further Neuropsychological Testing Recommended

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature [ ] M.D. Date

 [ ] N.P. or P.A.

**6**

TO BE COMPLETED BY PROVIDER



**COGNITIVE TESTING (Effective 01/1/18)**

Cognitrax Computerized Testing: □ 96103 AND □ 96120

CNS-VS – Cognitive Assessment & Care Planning □ 99483

Covered Medicare Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No Impairment □ Further Neuropsychological Testing Recommended

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature [ ] M.D. Date

 [ ] N.P. or P.A.