MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

NAME: _____ DOB: _____ DATE: _____

BEHAVIORAL RISK FACTORS

PHYSICAL ACTIVITY

How many days a week do you usually exercise? _____ days per week.

On days when you exercise, for how long do you usually exercise? _____ minutes per day

How intense is your typical exercise? (Check one)

___ Light (like stretching or slow walking)

___Moderate (like brisk walking)

___I am currently not exercising

___Heavy (like jogging or swimming)

___Very heavy (like fast running or stair climbing)

NUTRITION

On a typical day, how many servings of fruits and/or vegetables do you eat? ___ servings

On a typical day, how many servings of high fiber or whole grain foods do you eat? ___servings

On a typical day, how many servings of fried or high-fat foods do you eat? ___servings

ORAL HEALTH

How often do you brush your teeth?

___At least once daily

___Most days of the week

___Seldom

___Never

Do you visit the dentist regularly? Yes ___ No ___

MOTOR VEHICLE SAFETY

Do you always fasten your seat belt when you are in the car? Yes ___ No ___

Do you ever drive after drinking, or ride with a driver who has been drinking? Yes ___ No ___

SUN EXPOSURE

Do you protect yourself from the sun when you are outdoors? Yes ___ No ___

DEPRESSION

STRESS/ANGER

How often is stress/anger a problem for you?

___Never, rarely

___Sometimes

___Often

___Always

How well do you handle the stress/anger in your life?
___I'm usually able to cope effectively
___At times I have problems coping
___I often have problems coping

GENERAL WELL-BEING
In general, would you say your health is?
___Excellent
___Very good
___Good
___Fair
___Poor

PAIN/FATIGUE
How many hours of sleep do you usually get each night? _____ hours
Do you have pain that interferes with performing desired activities? Yes ___ No ___
How often do you feel unusually tired?
___Never, rarely
___Sometimes
___Often
___Always

HEARING/VISION IMPAIRMENT
Do people complain that you turn the TV volume up too high? Yes ___ No ___
Do you find yourself asking people to repeat themselves? Yes ___ No ___
Do you have difficulty driving, watching TV, reading, or doing any of your daily activities because of your vision? Yes ___ No ___

ACTIVITIES OF DAILY LIVING
Do you need help with the telephone? Yes ___ No ___
Do you need help eating, bathing, getting dressed or using the toilet? Yes ___ No ___
Do you need help with shopping or preparing meals? Yes ___ No ___
Do you need help with managing money or your medication? Yes ___ No ___

FALL RISK ASSESSMENT
Have you fallen in the past year? Yes ___ No ___
Do you feel unsteady when you walk? Yes ___ No ___
Do you feel dizzy when you get up from a bed or chair? Yes ___ No ___

HOME SAFETY
Does your home have rugs in the hallways? Yes ___ No ___
Does your home have grab bars in the bathroom? Yes ___ No ___
Is there any clutter in your walking space at home? Yes ___ No ___

MEMORY LOSS

Do family members report that you have difficulty remembering things? Yes ___ No ___

END OF LIFE PLANNING

Do you have an Advance Directive, Living Will or Power of Attorney for Health Care (POA), in the case that an injury or illness causes you to be unable to make healthcare decisions?

___Yes

___No

Would you like further information regarding Advance Directives? Yes ___ No ___

_____ _____

Patient signature Date

Depression Screening	**Not at all**	**Several days**	**More than half the days**	**Nearly all the days**
Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?				
Over the past 2 weeks, how often have you felt down, depressed, or hopeless?				

If completed by someone other than the patient:

_____ _____ _____

Print Name/Relationship to patient Signature Date

_____ _____

Provider signature Date

Provider Use ONLY

Mini-Cog test ___/5

1. Word recollection
   (Banana, Sunrise, Chair) 3pts
2. Clock drawing 11:10 2pts