MEDICARE ANNUAL WELLNESS ASSESSMENT

PLEASE COMPLETE AND BRING TO YOUR WELLNESS VISIT

Patient Name	DOB / /	Age
Allergies to Medication		
MEDICAL/SURGICAL HISTORY		
CURRENT MEDICAL PROBLEMS AND PAST PROBLEMS AND SURGERIES	DATE	HOSPITALIZED?

What date were you Medicare eligible?	
What is your primary language?	
Have you been in the Emergency Room, hospital, or skilled nursing facility in the last 6-12 months? If YES, how many times?	
Tobacco use? YES NO SMOKE / CHEW (CIRCLE ONE) Packs per day?	
Alcohol use? YES NO If YES, how many drinks per day?	
Drug use? YES NO If YES, describe	

How many servings of fruits and vegetables do you have per day?	
How many days per week do you exercise? Duration? Type?	
How many children do you have? What is your occupation?	
Who do you live with?	
Do you use any assistive devices, such as a walker, cane, wheelchair, hospital bed, or bedside commode?	YES NO
Are you currently receiving services from Home Health, Social Services, or Physical Therapy?	YES NO

CURRENT MEDICATION LIST		
MEDICATIONS, SUPPLEMENTS, VITAMINS	**DOSAGE**	**DIRECTIONS**
**PLEASE ATTACH AN ADDITIONAL PAGE IF FURTHER SPACE IS NEEDED FOR MEDICATIONS*		

CURRENT PROVIDER/SPECIALISTS		
NAME	**SPECIALTY**	**REASON**

FAMILY HISTORY Please check box below and specify if Parent, Grandparent, or Sibling			
☐ Alcoholism	☐ Cancer	☐ High Cholesterol	☐ Obesity
☐ Arthritis	☐ Diabetes	☐ Hypertension	☐ Stroke
☐ Heart Disease	☐ Liver Disease	☐ Kidney Disease	☐ Thyroid Disease

Do you have an Advanced Directive/Living Will? YES NO
Do you currently have any pain? YES NO LOCATION?
If YES, severity on a scale of 1-10, 10 being the worst? 1 2 3 4 5 6 7 8 9 10
Do you routinely get a flu vaccine? YES NO
Have you had a pneumonia vaccine? YES NO
Have you had a shingles vaccine? YES NO
Do you have any skin breakdown or wounds? YES NO

HEARING LOSS SCREEN	
Do you have trouble hearing the TV or radio when others don't?	YES NO
Do you have to strain or struggle to hear/understand conversations?	YES NO
FALL SCREEN	
Have you had a fall in the last year?	YES NO
Have you had more than one fall in the last year?	YES NO
HOME SAFETY SCREEN	
Does your home have rugs, poor lighting, or a slippery bathtub/shower?	YES NO
Does your home have grab bars in bathrooms, handrails on steps or stairs?	YES NO
Does your home have functioning smoke alarms?	YES NO

INCONTINENCE SCREEN	
Do you leak urine or have trouble getting to a bathroom in time?	YES NO
FUNCTION SCREEN	
Do you live alone?	YES NO
Do you need help with preparing meals, transportation, shopping, managing your finances, or housekeeping?	YES NO
If YES, please specify	
Do you need help with bathing, dressing, using the toilet, eating, walking, getting in and out of bed or chairs?	YES NO
If YES, please specify	

ADVANCE CARE PLANNING

PATIENT CONSENT: “I CONSENT TO DISCUSS END-OF-LIFE ISSUES WITH MY HEALTHCARE PROVIDER.” YES NO

PATIENT/GUARDIAN SIGNATURE DATE

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
For office coding	0	+ ______	+ ______	+ ______
				=Total Score___________

If you checked off **any** problems, 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?			
☐ Not difficult at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

REVIEWED BY MD/PA-C DATE