Medicare Annual Wellness Subsequent Visit Questionnaire

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Please answer by checking the circle or filling in the blanks as appropriate.

Recent History: ○ I decline to answer

Have you been hospitalized over-night in the last year? Yes / No

If yes, the reason you were hospitalized: _____

Approximate date of hospitalization: _____

How many times a year do you see the dentist? _____

Social History: ○ I decline to answer

1. Please list any hobbies: (Knitting, woodworking, reading, etc.)

   _____

2. Please list any clubs, groups or service organizations: (Bridge, Lions, Church, etc.)

   _____

3. Please list any volunteer work that you do and where: (Hospital greeter, courier, soup kitchen, etc.)

   _____

4. Retired or working part or full time? Current or former occupation?

   _____

5. Do you have any pets? If so what kind?

   _____

6. Please list any people who are currently living with you and their relationship to you:
   (John-Husband, Jane-friend, Jill-granddaughter, etc.)

   _____

   _____

Hearing: (Please circle your answer) ◯ I decline to answer

I have hearing difficulties Yes / No

If you answered yes, please complete the next hearing questions. (Circle the best answer)

The hearing in my right ear is decreased: Slightly / Moderately / Significantly
The hearing in my left ear is decreased: Slightly / Moderately / Significantly
I wear hearing aids in: Both Ears / Right only / Left only

Abilities: (Please circle your answer) ◯ I decline to answer

I can use the phone without assistance Yes / No
I can prepare meals without assistance Yes / No
I can manage my medications without assistance Yes / No
I am able to drive a car without any problem Yes / No
I am able to arrange transportation without assistance Yes / No
I am able to do my own house work without assistance Yes / No
I am able to manage my financial matters without assistance Yes / No
I am able to shop without assistance Yes / No
I am able to do laundry without assistance Yes / No

Home Safety: (Please circle your answer) ◯ I decline to answer

I have steps to enter my home or stairs inside my house Yes / No
There are hand rails on the stairs Yes / No
I have loose throw rugs in my house Yes / No
I have clutter on the floors Yes / No
I have poor household lighting Yes / No
I have grab bars in the bathroom Yes / No
I have fallen more in the past year Yes / No
If yes, _____ approximate number of times

Please list all other doctors and their phone numbers, which you currently see:
(Include eye doctors, dentist, podiatrist, medical equipment supplier, etc. Attach additional list if not enough space.)

Name:	Phone or Clinic Information:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Thank you for completing this health assessment. Please give it to the nurse at your appointment.