Medicare Annual Wellness Visit Questionnaire

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

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

Diet: ○ I decline to answer

I eat a well-balanced diet Yes / No

I eat _____ (number) of items of junk food per day
I drink _____ (number) of cups of caffeinated coffee or tea per day
I drink _____ (number) of cans/bottles of soda pop per week

Type of soda pop: Name _____ Regular or Diet? and Caffeine or Decaf? (Circle type)

Dental: ○ I decline to answer

I see a dentist _____ times a year.

I have difficulty chewing with my teeth or dentures Yes / No

Exercise: ○ I decline to answer

- ○ I never exercise
- ○ I exercise _____ times a week
- ○ I exercise _____ minutes per _____

Type of exercise: (Check all that apply)

○ Walk	○ Strength train	○ Other:_____
○ Bike	○ Cardio	
○ Swim	○ Stretching	

Tobacco Use: ○ I decline to answer

- ☐ I have never smoked
- ○ I am a former smoker - Circle type: cigarette/cigar/pipe
  I smoked for _____ years I quit smoking in _____ I smoked ____ cigarettes a day
- ○ I am a current smoker - Circle type: cigarette/cigar/pipe
  I have been smoking for ____ years I smoke ____ cigarettes a day
- ☐ I have never used smokeless tobacco or chewing tobacco
- ○ I am a former smokeless tobacco or chewing tobacco user
  I have used for _____ years How often used_____
- ○ I am a current smokeless tobacco or chewing tobacco user
  I have been using for _____ years How often I use it_____

I am ready to quit using tobacco Yes / No

○ I am cutting back ○ I am interested in information to help me quit

Alcohol Use: ○ I decline to answer

- ☐ I have never used alcohol
- ○ I drank in the past but no longer do
- ○ I drink _____ (number of) drinks per _____ (day, week, month, year)
  Type of alcohol _____ (Beer, Whiskey, Gin etc.)
- ○ I am in recovery

I am concerned about my alcohol use Yes / No
My family is concerned about my alcohol use Yes / No
I am ready to quit drinking alcohol Yes / No

- ○ I have a tolerance to alcohol
- ○ I need to drink alcohol in the morning
- ○ I am cutting back on my use of alcohol
- ○ I am interested in information about quitting

Illicit Drug Use: ○ I decline to answer

- ☐I have never used illicit drugs

Please answer the one that applies best:

- ○I am a former user of illicit drugs
- ○I am a current user of _____ (Name of drug)
- ○ I use _____ (number of) times per _____ (day, week, month, year)

I am ready to quit using illicit drugs Yes / No

○I am in the process of trying to quitting ○ I would like resources about quitting

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 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:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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