

Annual Wellness Visit Questionnaire

Answering these questions will help you and your health care provider develop a personalized prevention plan to help you stay healthy and plan for future health services.

Date	Last Name:	First Name:	Middle Name:
Date of Birth: / /	Age:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____			
Language spoken in home:			
What is your height? _____ feet _____ inches			What is your weight? _____ pounds
Allergies (including allergies to medicines) _____			

Please list medicines you are taking. Include all prescriptions, non-prescription, and over the counter (OTC) medicines- including inhalers, vitamins, herbs and supplements.				
Medicine Name	How much? (Strength or dose)	Why am I taking?	How often do I take this medicine?	Who ordered this medicine?

Pharmacy Information: Please list the local and mail order pharmacies where you get your prescriptions filled.			
Pharmacy	Address	Phone Number	Fax Number
		()	()
		()	()
		()	()

Please list the doctors and providers who are involved in your care.			
Name of the doctor/provider	Reason for care	Date last seen	Phone Number
			()
			()
			()
			()
			()

Medical Vendors: Please list the agencies that supply your home nursing services or medical equipment.						
Name of Company	What is supplied			Phone Number		
				()		
				()		
				()		
Medical/Family History: Please check the appropriate boxes.						
Disease	Self	Father	Mother	Brother/ Sister	Children	
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Past Illnesses (self):						
Past Hospitalizations (self):						
Please check the appropriate boxes.			<i>Almost all of the time</i>	<i>Most of the time</i>	<i>Some of the time</i>	<i>Almost never</i>
In the <u>past 4 weeks</u> , how often have you feel down, depressed, or hopeless?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the <u>past 4 weeks</u> , how often have you felt little interest or pleasure in doing things?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the <u>past 4 weeks</u> , how often have your feelings caused you distress or interfered with your ability to get along socially with family or friends?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the <u>past 4 weeks</u> , how often have you felt nervous, anxious, or on edge?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the <u>past 4 weeks</u> , how often were you not able to stop worrying or control your worrying?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often is stress a problem for you in handling your: health, finances, work, family, or social relationships?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you get the social and emotional support you need?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you fasten your seat belt when you are in a car?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the <u>past 4 weeks</u> , how often have you felt sleepy during the daytime?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many hours of sleep do you usually get each night?			_____ hours			
Do you snore or has anyone told you that you snore?			<input type="checkbox"/> Yes		<input type="checkbox"/> No	

Please check the appropriate boxes or fill in the blank.	
In the <u>past 4 weeks</u> , how much pain have you felt?	<input type="checkbox"/> A lot <input type="checkbox"/> Some <input type="checkbox"/> None
If your blood pressure was checked <u>within the past year</u> , what was it when it was last checked?	<input type="checkbox"/> at or below 120/80 <input type="checkbox"/> 140/90 or higher <input type="checkbox"/> 120/80 to 139/89 <input type="checkbox"/> I'm not sure
If your cholesterol was checked <u>within the past year</u> , what was your total cholesterol when it was last checked?	<input type="checkbox"/> below 200 <input type="checkbox"/> 240 or higher <input type="checkbox"/> 200-239 <input type="checkbox"/> I'm not sure
If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?	<input type="checkbox"/> below 100 <input type="checkbox"/> 126 or higher <input type="checkbox"/> 100-125 <input type="checkbox"/> I'm not sure
If you have diabetes, and if you have had your hemoglobin A1c level checked in the past year, what was it the last time you had it checked?	<input type="checkbox"/> 6 or lower <input type="checkbox"/> 8 or higher <input type="checkbox"/> 7 <input type="checkbox"/> I'm not sure
In the <u>past 4 weeks</u> , did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the <u>past 4 weeks</u> , did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In general, would you say your health is...?	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Very Good <input type="checkbox"/> Poor <input type="checkbox"/> Good
How would you describe the condition of your mouth and teeth? (including false teeth or dentures)	<input type="checkbox"/> Excellent <input type="checkbox"/> Fair <input type="checkbox"/> Very Good <input type="checkbox"/> Poor <input type="checkbox"/> Good
In a typical week, how many days do you exercise?	_____ days per week <input type="checkbox"/> I am currently not exercising
On days when you exercise, how long do you typically exercise?	_____ minutes per day
On days when you exercise, how intense is your typical exercise?	<input type="checkbox"/> Light (like stretching or slow walking) <input type="checkbox"/> Moderate (like brisk walking) <input type="checkbox"/> Heavy (like jogging or swimming) <input type="checkbox"/> Very heavy (like fast running or stair climbing)
In a typical week, how many days do you drink alcohol?	_____ days per week
In a typical week, how often do you have 4 or more alcoholic drinks on one occasion?	<input type="checkbox"/> Never <input type="checkbox"/> More than 3 times per week <input type="checkbox"/> Once a week <input type="checkbox"/> 2-3 times per week
Do you ever drive after drinking, or ride with a driver who has been drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the <u>past 4 weeks</u> , have you used tobacco? (includes smoking or smokeless tobacco products)	<input type="checkbox"/> Yes <input type="checkbox"/> No (list type) _____
If you have smoked or used smokeless tobacco products in the <u>past 4 weeks</u> , would you be interested in quitting tobacco use within the next month?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please fill in the blank.	
In a typical week, how many servings of fruits and vegetables do you eat each day? (1 serving= 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup= the size of a baseball)	_____ servings per day
In a typical week, how many servings of high fiber or whole grain foods do you eat each day? (1 serving= 1 slice of 100% whole wheat bread, 1 cup of whole- grain or high- fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta)	_____ servings per day
In a typical week, how many servings of fried or high-fat foods do you eat each day? (Examples include: fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise)	_____ servings per day
In a typical week, how many <i>sugar-sweetened</i> (not diet) beverages do you consume <i>each day</i> ?	_____ sugar sweetened beverages per day

For Office Use Only:
 Comments: _____

Reviewed by: _____ Date: _____

Reference: Sample Health Risk Assessment (A framework for patient-centered health risk assessments- providing health promotion and disease prevention services to Medicare beneficiaries. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.) Available at <http://www.cdc.gov/policy/ohsc/hra/>

Senior/Medicare Preventive Services Plan

These are typical preventive services and health screenings recommended for individuals 65 years of age and above. Please review these health services with your doctor to see which ones are appropriate for you based on your clinical risk factors and insurance coverage.

Please Note: Many of the health services listed below are not included in the free Annual Wellness Visit. These health services are covered according to Medicare's usual coverage guidelines. If you have questions about Medicare coverage for these preventive services, please contact 1-800 MEDICARE or www.medicare.gov.

Preventive Service	Last Received (Date)	Up-to-date (Yes/No)
One-time Initial Preventive Physical Examination (IPPE)		One-time benefit
Annual Wellness Visit (AWV)		
Abdominal Aortic Aneurysm Screening (if at risk) ¹		
Bone Mass Measurement		
Cholesterol/LDL		
Colorectal Cancer Screenings (any of the following)		
Fecal Occult Blood Test		
Flexible Sigmoidoscopy		
Colonoscopy		
Diabetes Screenings		
Glaucoma Screening		
Hearing Screening		
HIV Screening		
Immunizations (Based on guidelines)		
Flu		
Hepatitis B		
Pneumococcal		
Tetanus ²		
Tdap		
Zostavax		
Mammogram (screening)		
Pap Test +/- HPV test ³		
Prostate Cancer Screening Discussion		
Tobacco Use Cessation Counseling		
Vision Screening		
Other		

¹ A Medicare beneficiary with certain risk factors for AAAs may receive a referral for a one-time preventive ultrasound screening for the early detection of AAAs. Important: Eligible beneficiaries must receive a referral for an ultrasound screening for AAA as a result of an IPPE.

² Medicare does not cover a Tetanus vaccine for prevention.

³ Ask your doctor if this is appropriate for you.

You can also track your preventive services on MyMedicare.gov. Get a two-year calendar of the Medicare-covered tests and screenings you are eligible for and print a personalized "on the go" report to take to your next doctor's appointment.