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Medical Group

MEDICARE ANNUAL WELLNESS QUESTIONNAIRE

Patient Name: _____ MRN: _____ Date: _____

Please complete this checklist before seeing your doctor or nurse. Your responses will help us provide the best care.
We will also perform a vision test.

List of current providers you see: ☐ NONE ☐ N/A

1) Condition:
2) Condition:
3) Condition:
4) Condition:
5) Condition:

List of current medical equipment suppliers:
(oxygen, CPAP, etc) ☐ NONE ☐ N/A

1)
2)
3)
4)
5)

List of current supplements including doses: ☐ NONE ☐ N/A

1)
2)
3)
4)
5)
6)

General Health: Check appropriate response

1. In general, would you say your health is: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
2. Do you have dental problems that have not received proper attention? ☐ Yes ☐ No
3. Each night, how many hours of sleep do you usually get? _____# of hours
4. Do you snore or has anyone told you that you snore? ☐ Yes ☐ No
5. Have you noticed difficulty with your hearing? ☐ Yes ☐ No
6. Do you have either of the following? ☐ Ringing in ear ☐ Dizziness ☐ Discharge
7. Have you had a recent eye exam? ☐ Yes ☐ No

   Eye Exam (Ophthalmologist) Provider Name: _____ Date of last eye exam: _____

Nutrition

8. In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? _____ # of servings per day
   (One serving=1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 med piece of fruit)
9. In the past 7 days, how many servings of fried or high fat foods did you typically eat each day? _____ # of servings per day
   (Examples include fried chicken or fish, bacon, french fries, potato chips, donuts, foods made with cream)
10. In the past 7 days, how many servings of sugar-sweetened (not diet) beverages did you typically consume each day? _____ # of servings per day

Exercise

11. In the past 4 weeks, how many days did you exercise? _____ days
12. On days when you exercised, for how long did you exercise? _____ # of hours per day _____ # of minutes per day
13. How intense was your typical exercise?
    ☐ Light (like stretching or slow walking) ☐ Moderate (like brisk walking) ☐ Heavy (like jogging or swimming)
    ☐ Very heavy (like fast running or stair climbing) ☐ I am currently not exercising

Alcohol: In the past four weeks, on average how many drinks of wine, beer or other alcoholic beverages did you drink?
☐ None ☐ 1 or less ☐ 2-5 per week ☐ 6-9 per week ☐ 10 or more per week

How many times in the last year have you had 4 or more drinks in a day?
☐ Never ☐ A few times a year ☐ Monthly ☐ Weekly ☐ Daily or almost daily

PATIENT LABEL

Tobacco: In the last 30 days, have you used tobacco? Smoked: ☐ Yes ☐ No Smokeless tobacco product: ☐ Yes ☐ No
Would you be interested in quitting tobacco use within the next month? ☐ Yes ☐ No

Depression

14. In the past 2 weeks, how often have you felt little interest or pleasure in doing things?
☐ Nearly every day ☐ More than half the days ☐ Several days ☐ Not at all
15. In the past 2 weeks, how often have you felt down, depressed or hopeless?
☐ Nearly every day ☐ More than half the days ☐ Several days ☐ Not at all

Home Safety

16. Does your home have: Rugs in the hallway? ☐ Yes ☐ No Handrails on the stairs? ☐ Yes ☐ No
Grab bars in the bathroom? ☐ Yes ☐ No Good lighting? ☐ Yes ☐ No

Activities of Daily Living

17. In the past 7 days, did you need help from others to perform everyday activities such as sitting, getting dressed, grooming, bathing, walking or using the toilet? ☐ Yes ☐ No
If yes, which area(s): _____
18. In the past 7 days, did you need help from others to take care of such things as laundry, housekeeping, banking, shopping, food preparation, transportation or taking your medications? ☐ Yes ☐ No
If yes, which area(s): _____
19. Do you need help writing checks or managing your finances? ☐ Yes ☐ No
20. Do you always fasten your seatbelt when you are in a car? ☐ Yes ☐ No ☐ Sometimes
21. Have you fallen two or more times in the past year? ☐ Yes ☐ No
22. Do you have an advance health directive or POLST? ☐ Yes ☐ No
a. If yes, has anything changed? ☐ Yes ☐ No
b. If no, would you like to receive more information? ☐ Yes ☐ No
23. Do you currently have any pain?
☐ No pain ☐ Very mild pain ☐ Mild pain ☐ Moderate pain ☐ Severe Pain
What do you take or do to manage your pain? _____
Do you take more pain medication than what is prescribed? ☐ Yes ☐ No

In addition to the no cost Medicare preventive exam, I would like the provider to address the following items, if there is time.
I understand that my regular personal copay, deductible and/or co-insurance will apply as the below is a separate, billable type of visit.
Please be advised that the assessment of new symptoms, chronic conditions, complete physical exam, and/or additional concerns may be subject to additional charges.

Chronic conditions:
1) _____
2) _____
3) _____
4) _____
5) _____

Current medication refill requests:
1) _____
2) _____
3) _____
4) _____
5) _____

New Problems: Please include symptoms and duration
1) _____
2) _____
3) _____
4) _____

Please sign here acknowledging the above:
Patient/Legal Representative: _____ Date: _____ Time: _____
If signed by other than patient, indicate relationship: _____
Print Name (Legal Representative): _____
Reviewed by (Provider): _____ Date: _____ Time: _____

PATIENT LABEL