Medicare Annual Wellness Visit
Welcome to Medicare Form

Patient Name: _____ Date of Birth:_____
Primary Care Provider's Name: _____
Does someone at home help you with your health care?

Caregiver Name: _____ Phone number: _____
How do you know this person? (For example, is this your sister, your father, or your friend, a hired caregiver/nurse, or do you live in assisted or independent living community?

Name of specialists or other healthcare providers:

Name	They help take care of my:	Last Visit Date:	Phone number (if known)

Health problems or diagnoses experienced by your family members that are new <u>within the past year:</u>

Your Mother:	Your Father:	Your Siblings:	Your Children:

Changes in Your Health History:
Have you had any new surgeries, procedures or new medical diagnosis in the last year? If so, please list below.
(Please list known dates of last colonoscopy, cologuard, mammogram, or bone density scan)

1.	4.
2.	5.
3.	6.

How Healthy do you feel today? (Circle all that apply):

I feel well today. I feel my health is getting better.
I feel my health is getting worse. I feel unwell today.
I am having these problems: _____

Do any of the following health risks apply to you? (Circle all that apply):

Feelings of anxiety or depression
Physical inactivity/limited mobility
Trouble with my memory
Second Hand Smoke
Inadequate nutrition/access to food
Increased stress
Social Isolation
Trouble with vision or hearing
Poor nutrition/lack of balanced diet
Other: _____

ACTIVITIES OF DAILY LIVING ASSESSMENT

On a normal day do you need help with any of the following things?

Check YES or NO	**YES**	**NO**		**YES**	**NO**
Feeding myself			Using the telephone		
Brushing my hair or teeth			Managing my medications		
Using the toilet			Doing basic housework		
Showering or bathing			Handling transportation		
Getting dressed			Managing my finances		
Walking or moving from one place to another			Shopping or preparing my meals		

SMOKING ASSESSMENT (Please check which best describes your smoking status):

___ Non-smoker (never smoked)
___ Past smoker Year Quit_____ Packs/day smoked (average)_____
___ Current smoker Packs/day currently smoke (average)____ Number of years Smoked _____
Have you tried quitting in the past? _____
Are you wanting to quit smoking now? _____

SUBSTANCE USE DISORDERS	**YES**	**NO**
Do you use any illegal drugs or take any prescription medications that have not been prescribed to you?		

(Please Describe): _____

ALCOHOL ASSESSMENT	**YES**	**NO**
Do you consume alcoholic beverages?		

How many nights a week do you consume alcoholic beverages? _____

When you consume alcoholic beverages, how many drinks do you consume in one evening? _____

What type of alcoholic beverages do you consume? _____

VISION ASSESSMENT	**YES**	**NO**
Have you had an eye exam in the last 12 months?		

Eye Doctor's Name: _____ Date of Last Eye Exam: _____

HEARING ASSESSMENT	YES	NO
Do you wear hearing aids?		
Are you currently under the care of an audiologist or Ear Nose and Throat specialist (ENT) that has tested your hearing?		
Name of Specialist _____		

FALLS	YES	NO
Have you fallen in the last year?		
Do you live alone?		
Do you feel unsteady standing or walking		
Do you worry about falling?		
Do you use a cane or a walker?		

BLADDER CONTROL	YES	NO
Is bladder control a problem for you?		
In the past 60 days, has urine leakage changed your daily activities or interfered with your Sleep?		
If urine leakage is a problem for you, would you be willing to try:		
Medications		
Exercise		
Surgery		

MEDICATIONS	YES	NO
In the last two weeks have you forgotten to take your medications?		
Do you have any questions on how and when to take your medications?		
Do you have any specific medications that are too expensive?		
Do you have any unanswered worries or questions related to your medication side effects?		

PHYSICAL HEALTH (circle what best describes you)

How often does physical health interfere with your daily activities?

Almost never	Occasionally	Frequently

How often do you choose to take the stairs over an elevator or escalator?

Almost never	Occasionally	Frequently

Approximately how many days a week are you physically active?

0 – 1 days	2 - 3 days	4 or more days

Are you as active as other persons your age?

YES	NO

Name:_____ DOB:_____ Date of Service_____

EMOTIONAL HEALTH

How would you describe your emotional health?

Calm	Energetic	Downhearted

How many hours of sleep do you typically get each night?

5 or less hours	6 – 7 hours	8 or more hours

In the last month, have you accomplished less that you would like or been careless while performing daily activities or at work?

YES	NO

In the last month, has your emotional health (feeling anxious or depressed) interfered with your daily activities?

YES	NO

DEPRESSION SCREENING

Over the past two weeks, have you felt anxious, down or depressed? (Circle one):

Yes No

Over the past two weeks, have you experienced little interest or pleasure in doing things? (Circle one):

Yes No

Mood Assessment

	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 asleep, staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired of having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself – or that you're 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
	Totals				

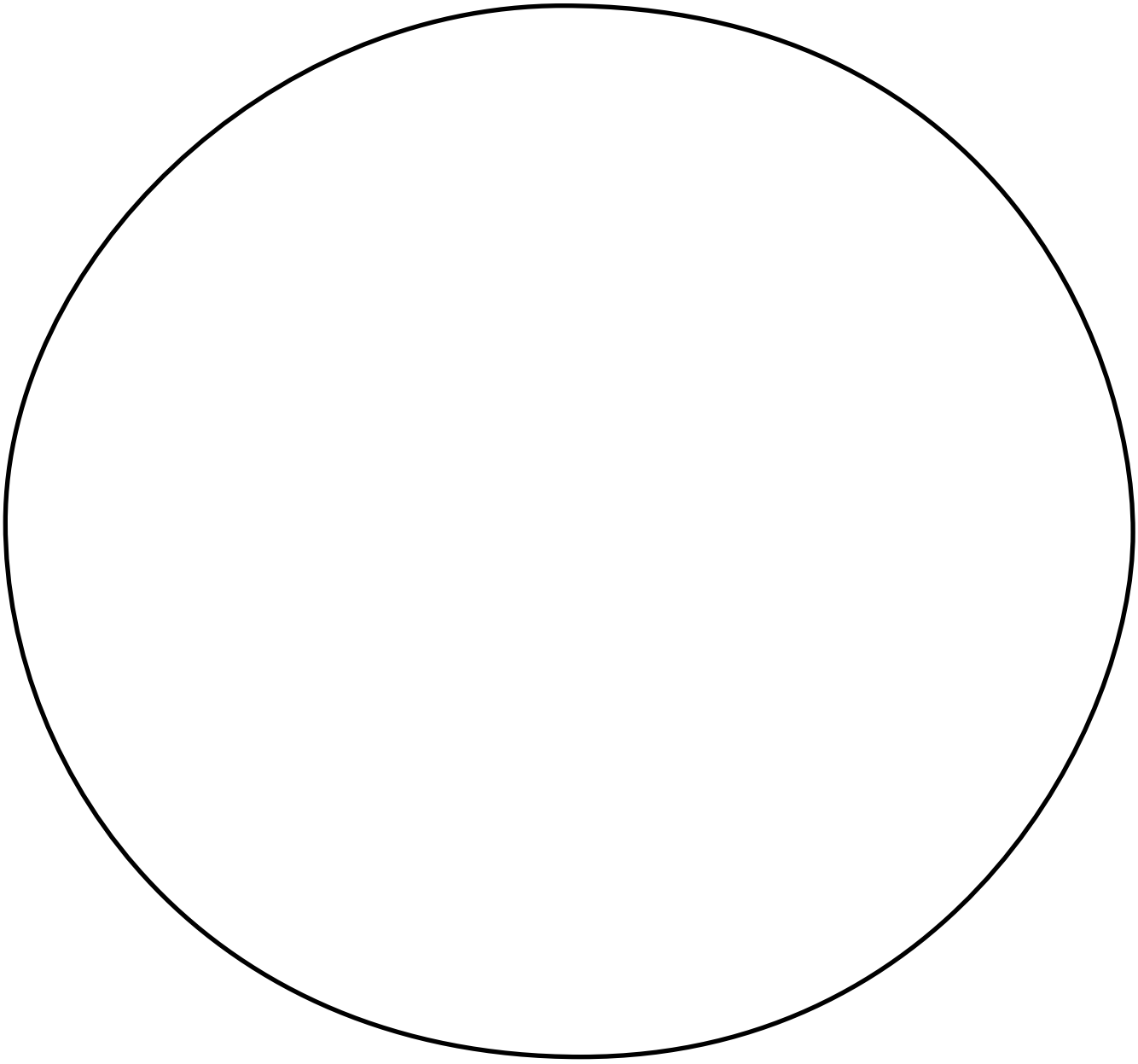
If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

Name:_____ DOB:_____ Date of Service_____

Mini-Cog Assessment

(Please wait to fill this out until your appointment. You will be given instructions at that time.)



Word recall: _____

_____ _____ _____

Name:_____ DOB:_____ Date of Service_____