PATIENT NAME:_____ **Date of Birth:** _____

THE FAMILY HEALTH CENTERS
ASHEVILLE I ARDEN I HOMINY VALLEY

MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Today's Date: _____

The Annual Wellness Visit is for preventative health and provided by Medicare. This is not a visit to evaluate new or ongoing medical problems, and does not cover the management of medical problems such as labs/prescriptions/etc. Should you need an appointment for a medical problem, a co-pay would be required and it would need to be scheduled as a separate appointment.

Is this information provided by the patient? ☐ Yes ☐ No

If not, who is providing the information ? _____

In general, how would you rate your current health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

CURRENT MEDICINES AND MEDICAL CONDITIONS

☐ **I don't take medications** (if checking this box please continue on to page 2)

During the past WEEK, how often did you forget to take or decide not to take one or more of your medications?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

How sure are you that you understand the reason why you take each of your medications?

☐ Very sure ☐ Somewhat sure ☐ Not very sure

How confident are you that you can manage your medical conditions from day-to-day?

☐ Very confident ☐ Somewhat confident ☐ Not very confident

ACTIVITIES OF DAILY LIVING

In the past WEEK, have you needed help with any of the following activities?

Using the toilet:	☐ YES	☐ NO
Dressing:	☐ YES	☐ NO
Getting in/out of chairs:	☐ YES	☐ NO
Eating:	☐ YES	☐ NO
Bathing:	☐ YES	☐ NO
Making it to the restroom:	☐ YES	☐ NO
Taking medications:	☐ YES	☐ NO
Laundry/housework:	☐ YES	☐ NO
Shopping:	☐ YES	☐ NO
Managing money:	☐ YES	☐ NO
Using the telephone:	☐ YES	☐ NO
Preparing meals:	☐ YES	☐ NO
Traveling:	☐ YES	☐ NO

In the last YEAR, have you lost your urine and gotten wet?

☐ YES ☐ NO

HEARING

Do you have concerns about your hearing?

☐ YES ☐ NO

If YES, would you like to schedule further evaluation of your hearing?

☐ YES ☐ NO

MEMORY

In the last MONTH, how often did you have trouble remembering/thinking clearly?

☐ Never ☐ Sometimes ☐ Usually ☐ Always

FALLS

Do you feel unsteady on your feet?

☐ YES ☐ NO

Do you worry about falling?

☐ YES ☐ NO

Have you fallen in the past YEAR?

☐ YES ☐ NO

Number of times: _____

Were you injured?

☐ YES ☐ NO

Have you had dizziness in the last 6 MONTHS?

☐ YES ☐ NO

Do you use any assistive devices for walking?

☐ YES ☐ NO

If yes, which ones?

☐ Another person

☐ Railing/objects around the house

☐ Cane

☐ Walker

☐ Wheelchair

Do you have scattered rugs in your home?

☐ YES ☐ NO

EYESIGHT

Because of your eyesight, do you have trouble driving a car, watching TV, reading, or doing daily activities?

☐ YES ☐ NO

Last eye exam:_____

HOSPITAL & ER VISITS

During the past 6 MONTHS, how many times did you go to the emergency room?

☐ None ☐ 1 or more times

Do you think you will go back to the emergency room again in the next 6 months?

☐ Not likely ☐ Possibly likely ☐ Very likely

During the past 6 MONTHS, how many times did you stay in the hospital overnight as a patient?

☐ None ☐ 1 or more times

Do you think you will go back to the hospital again in the next 6 months?

☐ Not likely ☐ Possibly likely ☐ Very likely

PAST SURGERIES

What surgeries have you had since your last wellness visit?

_____

_____

EXERCISE

In general, how many days do you exercise each week? _____ days

On days when you exercise, how long do you exercise? _____ minutes

How often do you do exercises to strengthen your arms and legs? _____ days

When you exercise, how intense is your typical exercise?

☐ Light (stretching/slow walking)

☐ Moderate (brisk walking)

☐ Heavy (jogging/swimming)

☐ Very heavy (fast running/climbing)

HOME MEDICAL EQUIPMENT

Do you use home medical equipment?

☐ YES ☐ NO

Who do you receive your home medical equipment from?

_____

_____

CAFFEINE USE

Do you drink caffeine daily?

☐ YES ☐ NO

If yes, how many servings per day? _____

TOBACCO USE

Please indicate your tobacco history:

☐ **Current tobacco user**

_____ packs per day

_____ cans per day

☐ **Former tobacco user**

Quit date: _____

Previously used:

_____ packs per day

_____ cans per day

☐ **Never used tobacco**

ALCOHOL USE

In a given week, how many days do you drink alcohol? _____ days

Do you ever drink more than 4 drinks in one sitting?

☐ YES ☐ NO

OTHER DRUG USE

Do you use any drugs for non-medical reasons?

☐ YES ☐ NO

FAMILY HISTORY

Have any of your immediate family members (parents, siblings, or children, living or deceased) had the following diseases?)

Heart Attack ☐ YES ☐ NO

If yes, who: _____

Stroke ☐ YES ☐ NO

If yes, who: _____

Diabetes ☐ YES ☐ NO

If yes, who: _____

Cancer ☐ YES ☐ NO

If yes, who and what type of cancer:

_____

LIVING SITUATION

Who lives with you? _____

_____

If you live alone, who can you call if you need help?

Contact Name: _____

_____

Contact phone number: _____

Do you have any animals/pets?

☐ YES ☐ NO

Type of pets: _____

_____

BARRIERS TO CARE

Do you have any problems getting the care you need because of any of the following reasons?

☐ Affording medications

☐ Transportation/driving to appointments

☐ Increased stress in your life

☐ Other: _____

VEHICLE SAFETY

Do you always wear a seatbelt when driving?

☐ YES ☐ NO

NUTRITION

What type of diet do you follow?

_____

ACTIVITIES:

What activities do you enjoy doing?

_____

PAST SCREENINGS / DATES:

Colon Cancer Screening: _____

Bone Density Screening: _____

Mammogram: _____

Lung Cancer Screening: _____

Abdominal Aortic Aneurysm: _____

PSA Screening: _____

Tetanus Vaccine: _____

Flu Vaccine: _____

Pneumonia Vaccine: _____

Shingrix Vaccine: _____

DEPRESSION SCREENING:

Over the last 2 WEEKS, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed, or hopeless

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

SPECIALTY PROVIDERS:

Outside of The Family Health Centers, list all physicians/providers you currently see:

Allergy:_____

Cardiologist (Heart): _____

Dermatology (Skin) : _____

Gastroenterology (Stomach/Liver): _____

_____

Endocrinology (Diabetes, Thyroid): _____

_____

Head, Neck, and Ear: _____

Nephrologist (Kidney):_____

Neurology: _____

OB/GYN: _____

Oncology (Cancer): _____

Ophthalmology (Eye Doctor): _____

Physical Therapy: _____

Podiatry (Foot): _____

Pain: _____

Pulmonology (Lungs): _____

Rheumatology: _____

Urology (Bladder): _____

Other: _____

_____

ADVANCE DIRECTIVES

Do you have a living will?

☐ YES ☐ NO

If you haven't already, please bring a copy of your living will to the office at your convenience.

Do you have a Durable (healthcare) Power of Attorney?

☐ YES ☐ NO

If yes, who is it? _____