MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR MEDICARE WELLNESS VISIT

(COMPLETION OF THIS FORM BY YOU IS REQUIRED BY MEDICARE IN ORDER TO QUALIFY FOR FREE MEDICARE ANNUAL WELLNESS VISIT).

DATE:___/___/____.

NAME: (FIRST,MIDDLE, LAST):____.

DETECTION OF COGNITIVE IMPAIRMENT

ARE YOU WORRIED ABOUT YOUR MEMORY ? **YES NO**

HOW OFTEN HAS CONFUSION OF MEMORY LOSS INTERFERED WITH YOU ABILITY TO WORK, VOLUNTEER OR ENGAGE IN SOCIAL ACTIVITIES ?

ALWAYS USUALLY SOMETIMES RARELY NEVER

DURING THE PASTY 30 DAYS, HOW OFTEN HAS A FAMILY MEMBER OF FRIEND PROVIDED CARE OR ASSISTED YOU BECAUSE OF CONFUSION OR MEMORY LOSS?

ALWAYS USUALLY SOMETIMES RARELY NEVER

FUNCTIONAL STATUS

DO YOU HAVE DIFFICULTY GETTING OUT OF A CHAIR OR CAR WITHOUT ASSISTANCE ? **YES NO**

DO YOU USE A CANE OR A WALKER? **YES NO**

DO YOU NOTICE ANY TROUBLE HEARING? **YES NO**

DO YOU HAVE PROBLEMS WITH VISION? **YES NO**

FALLS RISK SCREENINGS

IN THE LAST 12 MONTHS HAVE YOU FALLEN ? **YES NO**

IN YES, HOW MANY TIMES? ____.

WERE YOU INJURED AS A RESULT FROM THE FALL? **YES** **NO**

TOBACCO PRODUCT USE

SELECT ONE : **NONE** **CURRENT USE** **PAST USE**

TYPE OF PRODUCT: **SMOKE** **SMOKELESS**

HOW MUCH PER DAY?____.

HOW LONG?____.

ARE YOU WILLING TO QUIT? **YES** **NO**

DEPRESSION SCREENINGS

OVER THE PAST TWO WEEKS HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?

(1) LITTLE INTEREST OR PLEASURE IN DOING THINGS? **YES** **NO**

(2) FEELING DOWN, DEPRESSED OR HOPELESS? **YES** **NO**

ADVANCED DIRECTIVES

DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? **YES** **NO**

IF YES, PLEASE BRING A COPY WITH YOU FOR YOUR MEDICAL RECORDS.

VISION CARE

HAVE YOU RECENTLY HAD AN EYE EXAM OR EYE SURGERY ? **YES** **NO**

IF YES PLEASE LIST PROVIDER AND DATE OF LAST VISIT.

____.

DATE OF LAST VISIT: ___/___/___.

SCREENINGS AND IMMUNIZATIONS

(PLEASE FILL IN ANY SCREENINGS OR IMMUNIZATIONS THAT YOU MAY HAVE HAD DONE OUTSIDE OF OUR OFFICE BY ANOTHER PROVIDER SUCH AS GYNECOLOGIST, A PREVIOUS MEDICAL PROVIDER, OR AT THE PHARMACY)

SCREENINGS (DATE OF LAST)

MAMMOGRAM:__/__/___.

COLONOSCOPY:__/__/___.

HENOCULT (STOOL CARD):__/__/___.

ABDOMINAL AORTIC ANEURYSM (MALES WHO EVER SMOKED ONLY):__/__/___.

IMMUNIZATIONS (DATE OF LAST)

FLU SHOT:__/__/___.

PNEUMONIA VACCINE:__/__/___.

TETANUS:__/__/___.

SHINGLES VACCINE:__/__/___.

OTHER HEALTHCARE PROVIDERS YOU SEE ON A REGULAR BASIS:

PROVIDER NAME:____.

REASON FOR VISIT:____.

DATE OF LAST VISIT:__/__/___. **DATE OF NEXT VISIT:__/__/___.**

PROVIDER NAME:____.

REASON FOR VISIT:____.

DATE OF LAST VISIT:__/__/___. **DATE OF NEXT VISIT:__/__/___.**

SAFETY:

IF YOU HAVE GUNS IN YOUR HOME, ARE YOU AWARE OF SAFETY PROCEDURES SUCH AS KEEPING THE GUNS OUT OF REACH OF CHILDREN AND SAFELY LOCKED UP? **YES** **NO**

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME :________________________________. **DATE:_________________________.**

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	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 or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself — or that you are 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

FOR OFFICE CODING __*0*__ + ______ + ______ + ______

=Total Score: ______

If you checked off <u>any</u> problems, how <u>difficult</u> have these 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
☐	☐	☐	☐

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