MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Please answer by checking the box, selecting the answer or filling in the blanks as appropriate.

DIET: ☐ I decline to answer

I eat a well-balanced diet ☐ Yes ☐ No
I eat _____ (number) of items of junk food per day
I drink _____ (number) of cups of caffeinated coffee or tea per day
I drink _____ (number) of cans/bottles of soda pop per week

Type of soda pop: Name _____
☐ Regular ☐ Diet
☐ Caffeine ☐ Decaf

DENTAL: ☐ I decline to answer

I see a dentist _____ times a year.
I have difficulty chewing with my teeth or dentures ☐ Yes ☐ No

EXERCISE: ☐ I decline to answer

☐ I never exercise
☐ I exercise _____ times a week
☐ I exercise _____ minutes per _____
Type of exercise: (Check all that apply)
☐ Walk ☐ Strength train ☐ Other: _____
☐ Bike ☐ Cardio
☐ Swim ☐ Stretching

TOBACCO USE: ☐ I decline to answer

☐ I have never smoked
☐ I am a former smoker - Circle type: cigarette/cigar/pipe
I smoked for _____ years I quit smoking in _____ I smoked ____ cigarettes a day

☐ I am a current smoker - Select type: ☐ cigarette ☐ cigar ☐ pipe
I have been smoking for ____ years I smoke ____ cigarettes a day

☐ I have never used smokeless tobacco or chewing tobacco

☐ I am a current smokeless tobacco or chewing tobacco user
I have been using for _____ years How often I use it_____

☐ I am a former smokeless tobacco or chewing tobacco user
I have used for _____ years How often used_____

I am ready to quit using tobacco ☐ Yes ☐ No
☐ I am cutting back ☐ I am interested in information to help me quit

ALCOHOL USE: ☐ I decline to answer

☐ I have never used alcohol
☐ I drank in the past but no longer do
I drink _____ (number of) drinks per _____ (day, week, month, year)
Type of alcohol _____ (Beer, Whiskey, Gin etc.)
☐ I am in recovery

I am concerned about my alcohol use ☐ Yes ☐ No
My family is concerned about my alcohol use ☐ Yes ☐ No
I am ready to quit drinking alcohol ☐ Yes ☐ No

☐ I have a tolerance to alcohol
☐ I need to drink alcohol in the morning
☐ I am cutting back on my use of alcohol
☐ I am interested in information about quitting

ILLICIT DRUG USE: ☐ I decline to answer

☐ I have never used illicit drugs

Please answer the one that applies best:
☐ I am a former user of illicit drugs
☐ I am a current user of _____ (Name of drug)
☐ I use _____ (number of) times per _____ (day, week, month, year)

I am ready to quit using illicit drugs ☐ Yes ☐ No
☐ I am in the process of trying to quit ☐ I would like resources about quitting

SOCIAL HISTORY: ☐ I decline to answer

1. Please list any hobbies: (Knitting, woodworking, reading, etc.)

2. Please list any clubs, groups or service organizations: (Bridge, Lions, church, etc.)

3. Please list any volunteer work that you do and where: (Hospital greeter, courier, soup kitchen, etc.)

4. Retired or working part or full time? Current or former occupation?

5. Do you have any pets? If so what kind?

6. Please list any people who are currently living with you and their relationship to you:
(e.g., John-Husband, Jane-friend, Jill-granddaughter, etc.)

HEARING: (Select your answer) ☐ I decline to answer

I have hearing difficulties ☐ Yes ☐ No

If you answered yes, please complete the next hearing questions. (Select the best answer)

The hearing in my right ear is decreased:	☐ Slightly	☐ Moderately	☐ Significantly
The hearing in my left ear is decreased:	☐ Slightly	☐ Moderately	☐ Significantly
I wear hearing aids in:	☐ Both Ears	☐ Right only	☐Left only

ABILITIES: (Select the best answer) ☐ I decline to answer

I can use the phone without assistance	☐ Yes ☐ No
I can prepare meals without assistance	☐ Yes ☐ No
I can manage my medications without assistance	☐ Yes ☐ No
I am able to drive a car without any problem	☐ Yes ☐ No
I am able to arrange transportation without assistance	☐ Yes ☐ No
I am able to do my own housework without assistance	☐ Yes ☐ No
I am able to manage my financial matters without assistance	☐ Yes ☐ No
I am able to shop without assistance	☐ Yes ☐ No
I am able to do laundry without assistance	☐ Yes ☐ No

HOME SAFETY: (Select the best answer) ☐ I decline to answer

I have steps to enter my home or stairs inside my house	☐ Yes ☐ No
There are handrails on the stairs	☐ Yes ☐ No
I have loose throw rugs in my house	☐ Yes ☐ No
I have clutter on the floors	☐ Yes ☐ No
I have poor household lighting	☐ Yes ☐ No
I have grab bars in the bathroom	☐ Yes ☐ No
I have fallen in the past year	☐ Yes ☐ No

If yes, _____ approximate number of times

Please list all other doctors and their phone numbers, which you currently see:
(Include eye doctors, dentist, podiatrist, medical equipment supplier, etc. Attach additional list if not enough space.)

Name:	Phone:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Thank you for completing this health assessment. Please give it to the nurse at your appointment.