MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE

Providers and Suppliers of Your Medical Care

Please list all providers and suppliers of your medical care such as primary care physicans, specialty physicians, chiropractors, pharmacies, herbalists, and therapists.

Primary Care Physician(s)	Specialty

Other Patient Care Team Members	Specialty

Current Medications

Please include prescriptions, over-the counter medications, vitamins and supplements.

Medication Name	Dose	Route	Frequency

Medication Allergies

Daily Aspirin Use

Have you discussed taking a daily aspirin with your doctor? ☐ Yes ☐ No

Medical History

Please check the appropriate box for the conditions as they apply to you

Condition	Yes	Comments	Condition	Yes	Comments	Condition	Yes	Comments
Allergies			Depression			Heart Attack		
Anemia			Diabetes			Nerve/Muscle Disease		
Anxiety			Emphysema			Osteoporosis		
Arthritis			Reflux, Heartburn			Seizures		
Asthma			Glaucoma			Sickle Cell Anemia		
Blood Transfusion			Heart Murmur			Stroke		
Cancer			HIV/AIDS			Substance Abuse		
Cataracts			High Blood Pressure			Thyroid Disease		
Heart Failure			Kidney Disease			Tuberculosis		
Clotting Disorder			Meningitis			Ulcers		
COPD								

Other Medical History:

Surgical History

Female:

Surgery	Yes	Comments	Surgery	Yes	Comments	Surgery	Yes	Comments
Appendectomy			Cosmetic Surgery			Joint Replacement		
Brain Surgery			C-Section			Small Intestine Surgery		
Breast Surgery			Eye Surgery			Spine Surgery		
Gall Bladder			Fracture Surgery			Tubal Ligation		
Colon Surgery			Hernia Repair			Heart Valve Replacement		

Male:

Surgery	Yes	Comments	Surgery	Yes	Comments	Surgery	Yes	Comments
Appendectomy			Cosmetic Surgery			Prostate Surgery		
Brain Surgery			Eye Surgery			Small Intestine Surgery		
Breast Surgery			Fracture Surgery			Spine Surgery		
Gall Bladder			Hernia Repair			Heart Valve Replacement		
Colon Surgery			Joint Replacement			Vasectomy		

Other Surgical History:

Ninilchik Community Clinics

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Family History

Please check the apropriate box of the conditions that apply to your blood relatives.

Additional siblings and/or children can be added in the blank spaces below.

Relation	Name	Alive	Deceased	Alcohol Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Learning Disability	Mental Retardation	Miscarriages	Stroke	Vision Loss
Mother																							
Father																							
Sister																							
Brother																							
Daughter																							
Son																							

Family Hisotry Comments:

Social History

Alcohol Use

☐ Yes ☐ No

If Yes

Number of drinks per day: _____

Type(s) of alcoholic beverages: _____

Sexually Active

☐ Yes ☐ No ☐ Not Currently

If Yes

Circle apporopriate response(s) Partner(s): Male Female

Type of birth control/protection used: _____

Drug Use

☐ Yes ☐ No

If Yes

Number of times used per week: _____

List type(s) of recreational drugs used: _____

Tobacco Use

☐ Yes ☐ No Are you ready to Quit ☐ Yes ☐ No

If Yes: Complete appropriate responses below

☐ Current Every day Smoker? _____ Number of Packs per Day _____ Number of Years

☐ Current Smoker? (not daily) _____ Number of Packs per Week _____ Number of Years

☐ Former Smoker? Quit Date? _____

☐ Passive Smoker?

Social History continued.

Smokeless Tobacco Use:

☐ Yes ☐ No **If Yes:** Are you ready to Quit ☐ Yes ☐ No

Complete appropriate responses below

☐ Former Smoker? _____ Quit Date?
☐ Passive Smoker?

Behavioral Risk Factors

PHYSICAL ACTIVITY:

How Many days a week do you usually exercise?

☐ days per week

On days when you exercise, for how long do you usually exercise?

☐ minutes per day
☐ does not apply

How intense is your typical exercise? (Check one)

☐ Light (like stretching or slow walking)
☐ Moderate (Like brisk walking)
☐ Heavy (Like jogging or swimming)
☐ Very Heavy (Fast running or stair climbing)
☐ I am currently not exercising

Behavioral Risk Factors continued.

NUTRITION:

On a typical day, how many servings of fruits and/or vegetables do you eat? 1 serving =1 cup of fresh vegetables, 1/2 cup of cooked vegetables, or 1 medium piece of fruit, 1 cup= size of a baseball)

_____ servings per day

On a typical day, how many servings of high fiber or while grain foods do you eat? (1 serving 1 slice of 100% while wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, 1/2 cup of cooked cereal such as oatmeal, 1/2 cup of cooked brown rice, or white wheat pasta.)

_____ servings per day

On a typical day, how many servings of fried or high-fat foods do you eat? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)

_____ servings per day

Oral Health:

How often do you brush your teeth?

☐ At least once daily ☐ Most days ☐ Seldom ☐ Never

	Yes	No
Do you visit the dentist regularly?	☐	☐

Motor Vehicle Saftey

	Yes	No
Do you always fasten your seat belt when you are in the car?	☐	☐
Do you ever drive after drinking, or ride with a driver who has been drinking?	☐	☐

Sun Exposure

	Yes	No
Do you protect yourself from the sun when you are outdoors?	☐	☐

Biometric Measures

Blood Pressure

If your blood pressure was checked within the past year, enter the actual result, or check the appropriate response below.

BP: _____ / _____ OR

___Desiarable (at or below 120/80)	___High (140/90 or Higher
___Borderline High (120/80 to 139/89)	___Don't know/Not sure

Cholesterol

If your cholesterol was checked within the past year, enter the actual result, or check the appropriate response below.

Cholesterol: _____ _____ _____ _____

Total HDL LDL Triglycerides

Total	HDL	LDL	Triglycerides
___Desiarable (Below 200)	___Desiarable (Above 50)	___Desiarable (Below 130)	___Desiarable (Below 150)
___Borderline High (200-239)	___Borderline Low (40 -50)	___Borderline High (130-160)	___Borderline High (150-200)
___High (240 or Higher)	___Low (40 or Less)	___High (160 or Higher)	___High (200 or Higher)
___Don't know/Not sure	___Don't know/Not sure	___Don't know/Not sure	___Don't know/Not sure
___Does not apply	___Does not apply	___Does not apply	___Does not apply

Blood Glucose:

If your blood glucosel was checked within the past year, enter the actual result, or check the appropriate response below.

Blood Glucose: _____ OR

_____Desiarable (Below 200)
_____Borderline High (200-239)
_____High (240 or Higher)
_____Don't know/Not sure
_____Does not apply

Biometric Measures continued.

Have you ever been told by a doctor or a health professional that you have diabetes or high blood sugar?

☐ Yes ☐ No (If no, skip to next section)

If you have had your hemoglobin A1C level checked within the last year, enter the actual result, or check the appropriate response on the lines below.

Blood Glucose: OR

_____Desiarable (7 or lower)
_____Borderline High (7-8)
_____High (8 or Higher)
_____Don't know/Not sure
_____Does not apply

Psychosocial Risk Factors

Overweight/Obesity

What is your height? (Example: 5 feet, 6 inches = 5'6"

_____ Feet, _____ Inches

What is your weight?

_____ Pounds

Depression

Over the past 2 weeks, how often have you feld down, depressed, or hopeless?

☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never

Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?

☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never

Have your feelings caused you distress or interfered with your ability to interact socially with friends?

☐ Yes ☐ No

Psychosocial Risk Factors

During the past 6 months, how often have you felt sad or depressed?

☐ Almost all of the time ☐ Most of the time ☐ Some of the time ☐ Almost never

In general, how satisfied are yo with your life?

☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

Stress/Anger

How often is stress/Anger a problem for you?

☐ Never/rarely ☐ Sometimes ☐ Often ☐ Always

How well do you handle the stress/anger in your life?

☐ I usually cope effectively ☐ At times I have a problem coping ☐ I often have trouble coping

General Well-Being

In general, would you say your health is?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Social/Emotional Support

How often do you get the social and emotional support that you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely

Pain/Fatigue

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

_____ Hours

Do you have pain that interferes with performing desired activities?

Yes	No
☐	☐

How often do you feel unusually tired?

☐ Never/rarely ☐ Sometimes ☐ Often ☐ Always

Hearing Impairment

	Yes	No
Do people complain that you turn the TV volume up too high?	☐	☐
Do you find yourself asking people to repeat themselves?	☐	☐
Do you have trouble hearing in a noisy background?	☐	☐

Psychosocial Risk Factors continued

Activities of Daily Living

	Yes	No
Do you need help with the telephone		
Do you need help eating, bathing, getting dressed or using the toilet?		
Do you need help with shopping or preparing meals?		
Do you need help with managing money or your medication?		

Fall Risk Assessment

	Yes	No
Have you fallen in the past year?		
Do you feel unsteady when you walk?		
Do you feel dizzy when you get up from a bed or chair?		

Home Saftey

	Yes	No
Does your home have rugs in the hallways?		
Does your home have grab bars in the bathroom?		
Is there any clutter in your walking space at home?		

Memory Loss

	Yes	No
Do family members report that you have difficult remembering things?		

End of Life Planning

	Yes	No
Do you have an Advance Directive, Living Will or Power of Attorney for Healthcare (POA), in the case that an injury or illness causes you to be unable to make healthcare decisions?		

Print Name _____ **Relationship to patient** _____

Signature _____ **Date** _____