

Medicare Annual Wellness Visit Patient Questionnaire

Patient Name: _____ DOB: _____ Date: _____

Complete Burns Depression Checklist

List any new hospitalizations, major illnesses, or visits to emergency room:

Date	Reason	Location

List of current medications:

Medication	Dose	Reason for taking

Allergies:

Medication	Reaction

Do you require assistance with any of the following activities?

- | | | | |
|-------------------------------|--------------|--------------------|--------------|
| Ambulation | (yes / no) | Shopping | (yes / no) |
| Bathing and Grooming | (yes / no) | Housework | (yes / no) |
| Dressing | (yes / no) | Finances | (yes / no) |
| Eating | (yes / no) | Meal preparation | (yes / no) |
| Toileting | (yes / no) | Taking Medications | (yes / no) |
| Transferring (bed to chair) | (yes / no) | Driving | (yes / no) |

Have you had any falls? If so please explain.

Accident prevention:

- | | | | |
|--|--------------|-------------------------|--------------|
| Do you wear seatbelts in the car? | (yes / no) | | |
| Do you have smoke detectors at home? | (yes / no) | | |
| Do you have carbon monoxide detectors? | (yes / no) | | |
| Do you have a firearm in your home? | (yes / no) | If so, is it locked up? | (yes / no) |

