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.

<u>Accident prevention:</u>

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)

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Preventative screening:

Do you have any trouble hearing? (yes / no)
Do you wear a hearing aid? (yes / no)
Do you have trouble seeing? (yes / no)
Do you wear glasses? (yes / no) ? Contact lenses ? (yes / no)
Date of last vision exam with an optometrist or ophthalmologist:_____
Do you smoke? (yes / no) Have you tried to quit? (yes / no)
Are you interested in quitting smoking? (yes / no)

Please list the date of your most recent:

Pneumonia vaccine: _____
Shingles vaccine: _____
Influenza vaccine: _____
Hepatitis B vaccine: _____
Colonoscopy: _____
DEXA: _____

Females:
Mammogram: _____
Pap/pelvic: _____

Males:
Prostate exam: _____

List of all other providers / specialists you see:

Doctor's name	Specialty / Reason for seeing them