Sutter Health

Medicare Annual Wellness Visit Questionnaire

Name: ____________________________ Date of Birth:_____________Today's Date: ____________

What over the Counter Medications are you taking, including vitamins and supplements? Put more on back.	
Medications/Vitamins/Supplement	**Reason**
What other physicians or providers do you see, and for which problems? Put additional on back.	
Specialist	**Problem**
Where do you get your medical supplies? (Diabetes, ostomy supplies, etc.) Put additional on back.	
Medical Supplier	**Problem**

How do you rate your health? (Circle one) Excellent Good Fair Poor

Hearing/Vision Evaluation:

Do you have trouble hearing the television or radio when others do not? Yes No
Do you have to strain or struggle to hear or understand conversations? Yes No
Do you have trouble seeing, even with glasses? Yes No

Functional Evaluation:

Do you have trouble walking? Yes No
Do you need help climbing stairs? Yes No
Do you need help with bathing? Yes No
Do you need help with dressing? Yes No
Do you need help with telephone use? Yes No
Do you need help with transportation? Yes No
Do you need help with shopping? Yes No
Do you need help with preparing meals? Yes No
Do you need help with housework? Yes No
Do you need help with laundry? Yes No
Do you need help with taking medications? Yes No
Do you need help with managing money? Yes No
Do you have trouble concentrating, remembering or making decisions? Yes No

Depression Questionnaire: Over the last 2 weeks have you felt:

Down, depressed, or hopeless? Not at all Several days More than half the days Nearly every day
Little interest or pleasure in doing things? Not at all Several days More than half the days Nearly every day

Home Safety:

Do you have a working smoke alarm in your home? Yes No
Does your home have loose rugs in the hallway? Yes No
Does your home have poor lighting? Yes No
Does your home have grab bars in the bathroom? Yes No
Does your home have handrails on the stairs? Yes No
Do you live alone? Yes No
In the past 12 months, have you fallen? Yes No
In the past 6 months, have you experienced leaking of urine? Yes No

Advance Directive:

Do you have an Advance Directive? Yes No

Additional Questions

Have you felt unusual pain or fatigue in the last 14 days? Yes No
Have you felt unusual stress, anger, or loneliness in the last 14 days? Yes No
Do you use seatbelts? Yes No
Do you have questions about your diet? Yes No
Have you seen your dentist within the last year? Yes No
Do you exercise at least 3 times a week? Yes No