

Medicare Annual Wellness Visit Questionnaire Name: ______ Today's Date: _____

Medications/Vitamins/Supplement Specialist S	What over the Counter Medications are you taking, including vitamins and supplements? Put more on back.			
Where do you get your medical supplies? (Diabetes, ostomy supplies, etc.) Put additional on back. Medical Supplier Med	Medications/Vitamins/Supplement	Reason		
Where do you get your medical supplies? (Diabetes, ostomy supplies, etc.) Put additional on back. Medical Supplier Med				
Medical Supplier Good Fair Poor	What other physicians or providers do you see, and for which problems? Put additional on back.			
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 to strain or struggle to hear or understand conversations? Yes No Do you have trouble seeing, even with glasses? Yes No Do you need help with shopping? Yes No Do you need help with bathing? Yes No Do you need help with bathing? Yes No Do you need help with housework? Yes No Do you need help with dressing? Yes No Do you need help with housework? Yes No Do you need help with transportation? Yes No Do you need help with transportation? Yes No Do you need help with housework? Yes No Do you need help with transportation? Yes No Do you need help with managing wore? Yes No Do you need help with transportation? Yes No Do you need help with managing wore? Yes No Do you have trouble concentrating, remembering or waking decisions? Yes No Do you need help with managing wore? Yes No Degression 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 Hume Safety: Do you have a working smoke alarm in your home? Not at all Several days Nore than half the days Nearly every day Hume Safety: Do you have a working smoke alarm in your home? Yes No Does your home have loose rugs in the halthoom? Yes No Does your home have poor lighting? Yes No Does you have an Advance Directive? Yes No No Do you live alone? Yes No No Do you live alone? Yes No No No Have an Advance Directive? Yes No No Do you live alone? Yes No No No Yes No No No Yes No Yes N	Specialist	Problem		
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Do you use seatbelts? Yes No Have you seen your dentist within the last year? Yes No				
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Do you have questions about your diet? Yes No Do you exercise at least 3 times a week? Yes No	•			

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