Medicare Annual Wellness Visit Questionnaire

Date of Wellness Visit:_____

CARE TEAM: Current list of your medical providers and suppliers:

Name	Specialty	Reason

DEPRESSION SCREENING

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1.	Little interest or pleasure in doing things?	☐	☐	☐	☐
2.	Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
	PHQ-2 score:				
***PHQ-9 ONLY IF PHQ-2 EXCEEDS SCORE OF 3**					
3.	Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4.	Feeling tired, or having little energy?	☐	☐	☐	☐
5.	Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
6.	Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7.	Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐
	PHQ-9 score:				

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Psychosocial Assessment:			
Do you feel lonely or socially isolated most of the time?	☐ YES	☐ NO	
Do you feel angry most of the time?	☐ YES	☐ NO	
Is stress a problem for you?	☐ YES	☐ NO	
In general, how satisfied are you with your life?	☐ Very	☐ Mostly	☐ NOT
Pain Assessment:			**ANSWER**
Do you suffer from acute/chronic pain?	☐ YES	☐ NO	
Are you currently taking any form of pain medication? If so, please list.	☐ YES	☐ NO	_____
How long have you been taking this medication?			_____
Does the medication relieve your symptoms?	☐ YES	☐ NO	
Have you tried any methods for pain relief that didn't involve taking medication? If so, please list.	☐ YES	☐ NO	_____
Self-Health Assessment			
How do you describe your overall health?	☐ Good	☐ Fair	☐ Poor
How do you describe your overall physical functioning?	☐ Good	☐ Fair	☐ Poor
Is your blood pressure ever high?	☐ YES	☐ NO	
Is your cholesterol high?	☐ YES	☐ NO	
Do you have diabetes or high blood sugar?	☐ YES	☐ NO	
Behavioral Assessment			
Tobacco Screen			**ANSWER**
Do you currently smoke cigarettes?	☐ YES	☐ NO	
If yes, how many packs a day?			_____
Do you chew tobacco?	☐ YES	☐ NO	
Do you use e-cigarettes?	☐ YES	☐ NO	
Do you smoke a pipe or cigars?	☐ YES	☐ NO	
Are you a former smoker?	☐ YES	☐ NO	
If so, how long ago did you quit?			_____
How many years did you smoke?			_____
How many packs per day?			_____
Alcohol Use			
How many days per week do you drink alcohol on average?			_____
How many drinks do you have on a typical day?			_____
Do you ever have more than 5 drinks on one occasion?	☐ YES	☐ NO	
Physical Activity			
Do you routinely exercise?	☐ YES	☐ NO	
If so, how many days per week?			_____
For how long each day?			_____
What type(s) of exercise do you do?			_____

Sexual Practices			
Are you sexually active?	☐ YES	☐ NO	
Nutrition and Oral Hygiene			
Have you recently had any loss in appetite?	☐ YES	☐ NO	
Do you eat three meals a day?	☐ YES	☐ NO	
How often do you brush your teeth?			_____
How often do you floss your teeth?			_____
Do you have dentures?	☐ YES	☐ NO	
Motor Vehicle Safety			
Do you always fasten your seat belt when you are in the car?	☐ YES	☐ NO	
Do you ever drive after drinking alcohol or ride with a driver who has been drinking?	☐ YES	☐ NO	
Home Safety			
Does your home have a slippery tub or shower?	☐ YES	☐ NO	
Does your home have throw rugs?	☐ YES	☐ NO	
Does your home have grab bars in bathrooms?	☐ YES	☐ NO	
Does your home have a functioning smoke alarm?	☐ YES	☐ NO	
Does your home have handrails on stairs and steps?	☐ YES	☐ NO	
Risk for Falls Screen			
Have you fallen in the past year?	☐ YES	☐ NO	
If so, how many times?			_____
If so, were you injured?	☐ YES	☐ NO	
Activities of daily living			
Do you live alone?	☐ YES	☐ NO	
Do you need help with:			
Dressing?	☐ YES	☐ NO	
Using the restroom?	☐ YES	☐ NO	
Preparing meals?	☐ YES	☐ NO	
Transportation or shopping?	☐ YES	☐ NO	
Managing your finances?	☐ YES	☐ NO	
Doing laundry or housekeeping	☐ YES	☐ NO	
Hearing loss screen			
Do you have trouble hearing the TV when others do not?	☐ YES	☐ NO	
Do you have to strain to hear/understand conversations?	☐ YES	☐ NO	
Do you have hearing aids?	☐ YES	☐ NO	
Advanced Care Planning (Living Will etc)			
Do you have Advance Directives already executed?	☐ YES	☐ NO	
Would you like to discuss with your provider today?	☐ YES	☐ NO	