# Medicare Annual Wellness Visit
# Questionnaire

South Strand Internists & Urgent Care

## PATIENT DEMOGRAPHICS

Date: _____

Name: _____ _____ _____ Date of Birth: _____
*Last* *First* *Middle* *MM/DD/CCYY*

Home Address: _____ _____ _____ ____ _____
*Street* *Apt/Unit* *City* *State* *ZIP*

Gender: ☐ Female ☐ Male

Home Phone: _____ Day Phone: _____ Cell Phone: _____

SS#: _____

Next of Kin *(for emergency)*: _____

Name of Spouse: _____ Day Phone: _____

Referred by: _____

Insurance: Name: _____ Phone #: _____

Policy #: _____ Group #: _____

## CURRENT MEDICAL PROBLEMS

List any current medical problems or conditions

1.) _____ 7.) _____

2.) _____ 8.) _____

3.) _____ 9.) _____

4.) _____ 10.) _____

5.) _____ 11.) _____

6.) _____ 12.) _____

## PAST MEDICAL HISTORY

Childhood Illnesses

1.) _____ 3.) _____ 5.) _____

2.) _____ 4.) _____ 6.) _____

Chronic Illnesses

1.) _____ 3.) _____ 5.) _____

2.) _____ 4.) _____ 6.) _____

Last Eye / Glaucoma Exam: _____

Past Surgeries

| *Surgery* | *Date* | *Surgery* | *Date* |
|---|---|---|---|
| 1.) _____ | _____ | 4.) _____ | _____ |
| 2.) _____ | _____ | 5.) _____ | _____ |
| 3.) _____ | _____ | 6.) _____ | _____ |

Patient Name: _____ Date of Birth: _____

## PAST MEDICAL HISTORY CONTINUED

List any other hospital stays

| *Reason* | *Date* | *Reason* | *Date* |
|---|---|---|---|
| 1.) _____ | _____ | 4.) _____ | _____ |
| 2.) _____ | _____ | 5.) _____ | _____ |
| 3.) _____ | _____ | 6.) _____ | _____ |

Physicians / practitioners you currently see

| *Name / Specialty* | *Name / Specialty* |
|---|---|
| 1.) _____ | 3.) _____ |
| 2.) _____ | 4.) _____ |

## ALLERGIES

List any current allergies to medications, x-ray dyes or foods

| *Allergy* | *Reaction* |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## MEDICATIONS

List any medication that you currently take, including over-the-counter

| *Name* | *Strength* | *Direction* | *Prescribed by* |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No *If yes, how much?* _____

Are others concerned about your drinking? ☐ Yes ☐ No

Diet: ☐ Balanced ☐ Vegetarian ☐ Diabetic ☐ Low salt ☐ Low fat ☐ Low carb ☐ Other: _____

Education: ☐ High school ☐ College ☐ Some college ☐ Trade school ☐ Other: _____

Do you do some form of regular exercise every day? ☐ Yes ☐ No *If yes, how much?* _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Occupation: _____

List everyone in your household, including pets:

| | | | |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Do you wear seatbelts? ☐ Yes ☐ No

Have you ever smoked or chewed tobacco? ☐ Yes ☐ No *If yes, how much?* _____

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY CONTINUED

ROUTINE TASKS: *Please indicate if you do or do not need help performing these routine tasks*

| | | | |
|---|---|---|---|
| 1.) Feeding yourself | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 2.) Getting from bed to chair | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 3.) Getting to the toilet | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 4.) Getting dressed | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 5.) Bathing or showering | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 6.) Walking across the room *(includes using cane or walker)* | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 7.) Using the telephone | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 8.) Taking your medication(s) | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 9.) Preparing meals | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 10.) Managing money *(like keeping track of expenses or paying bills)* | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 11.) Moderately strenuous housework *(like doing the laundry)* | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 12.) Shopping for personal items *(like toiletries or medicines)* | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 13.) Shopping for groceries | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 14.) Driving | ☐ Yes | ☐ No | *If yes, who helps?* _____ |
| 15.) Climbing a flight of stairs | ☐ Yes | ☐ No | *If yes, who helps?* _____ |

FAMILY HISTORY

Please list any health problems and causes of death if applicable

| | *Living / Deceased* | *Age* | *Medical Problems* |
|---|---|---|---|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Brother(s) | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Sister(s) | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Mother's father | _____ | _____ | _____ |
| Mother's mother | _____ | _____ | _____ |
| Father's father | _____ | _____ | _____ |
| Father's mother | _____ | _____ | _____ |

Patient Name: _____ Date of Birth: _____

## HEALTH MAINTENANCE

Please record the last year you had the following. If you do not know, leave blank.

| | | | |
|---|---|---|---|
| Hep B *(shot)* | _____ | Hearing Exam | _____ |
| Flu vaccine *(shot)* | _____ | Hemocult | _____ |
| Pneumonia vaccine *(shot)* | _____ | Lipid Panel | _____ |
| Tetanus Diphtheria vaccine *(shot)* | _____ | Mammogram | _____ |
| Zostavax (Shingles) *(shot)* | _____ | Nutritional Therapy | _____ |
| Abdom. Aortic Aneurysm Screening | _____ | Pap Smear | _____ |
| Bone Density Scan | _____ | Pelvic Exam | _____ |
| Colonoscopy | _____ | Prostate Exam | _____ |
| Diabetes Self-Management Training | _____ | PSA Test | _____ |
| Echocardiogram | _____ | Rectal Exam | _____ |
| Eye Glaucoma Exam | _____ | Smoking Cessation | _____ |
| Glucose | _____ | | |

## HEARING

HEARING: *Check NO, YES, or SOMETIMES for **each** question*

| | | | |
|---|---|---|---|
| 1.) Do you find it difficult to follow a conversation in a noisy restaurant or crowded room? | ☐ Yes | ☐ No | ☐ Sometimes |
| 2.) Do you feel that people are mumbling or not speaking clearly? | ☐ Yes | ☐ No | ☐ Sometimes |
| 3.) Do you experience difficulty following dialogue in the theater? | ☐ Yes | ☐ No | ☐ Sometimes |
| 4.) Do you find it difficult to understand a speaker at a public meeting or religious service? | ☐ Yes | ☐ No | ☐ Sometimes |
| 5.) Do you find yourself asking people to speak up or repeat themselves? | ☐ Yes | ☐ No | ☐ Sometimes |
| 6.) Do you find men's voices easier to understand than women's? | ☐ Yes | ☐ No | ☐ Sometimes |
| 7.) Do you experience difficulty understanding soft or whispered speech? | ☐ Yes | ☐ No | ☐ Sometimes |
| 8.) Do you have difficulty understanding speech on the telephone? | ☐ Yes | ☐ No | ☐ Sometimes |
| 9.) Does a hearing problem cause you to feel embarrassed when meeting new people? | ☐ Yes | ☐ No | ☐ Sometimes |
| 10.) Do you feel handicapped by a hearing problem? | ☐ Yes | ☐ No | ☐ Sometimes |
| 11.) Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like? | ☐ Yes | ☐ No | ☐ Sometimes |
| 12.) Do you experience ringing or noises in your ears? | ☐ Yes | ☐ No | ☐ Sometimes |
| 13.) Do you hear better with one ear than the other? | ☐ Yes | ☐ No | ☐ Sometimes |
| 14.) Have you had any significant noise exposure during work, recreation, or military service? | ☐ Yes | ☐ No | ☐ Sometimes |
| 15.) Have any of your relatives (by birth) had a hearing loss? | ☐ Yes | ☐ No | ☐ Sometimes |

Patient Name: _____ Date of Birth: _____

**DEPRESSION SCREENING**

Please write your answer in the space provided

Key: ***0*** *– Not at all* ***1*** *– Several days* ***2*** *– More than half the days* ***3*** *– Nearly everyday*

1.) Little interest or pleasure in doing things _____

2.) Feeling down, depressed, or hopeless _____

**FALL RISK SCREENING**

Please check the appropriate answer

1.) Are you afraid of falling? ☐ Yes ☐ No

2.) Have you fallen in the past year? ☐ Yes ☐ No

*If yes, circle the circumstances surrounding the fall*

Answers:

*Tripped over something*

*Lightheadedness or palpitations prior to fall*

*Loss of consciousness*

*Injured*

*Needed to see a doctor*

*Able to get up on own*

**ADVANCED DIRECTIVE**

Do you have an Advanced Directive *(living will)*? ☐ Yes ☐ No

Notes: _____

_____

_____

Authorized Signature: _____ Date: _____

Reviewed by: _____ Date: _____