



MEDICARE ANNUAL WELLNESS VISIT

Please complete these papers and bring them to your upcoming appointment. It is very important that these are completed so you have time to sit and discuss them with your provider.

We prefer to schedule separate visits for your recheck and refill appointments so that we have the time we need to focus on any conditions, questions, or concerns you may have.

The Medicare Annual Wellness visit itself is covered at 100% by Medicare. However, if your provider has agreed **to combine your wellness visit with your recheck/refill visit, please know you may receive a bill for any labs drawn and the portion of your visit that covered your chronic conditions/refills, etc. just as you would on a separate visit.**

You will receive a text reminder of your appointment date if we have your current mobile phone number on your account.

We look forward to seeing you soon.



**Medicare Annual Wellness Visit
Health Risk Assessment**

Today's Date: _____

Patient Name: _____ DOB: _____

DEPRESSION SCREENING TOOL PHQ-9

In the past 2 weeks, how often have you been bothered by the following problems:	Not at all:	Several Days:	More than half of those days:	Nearly every day:
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, or that you're a failure, or have let yourself or family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Total Score:

If you checked off any of the problems in this section, 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 at all	Somewhat	Very difficult	Extremely difficult

GENERAL HEALTH

How is your overall health?	Excellent Good Fair Poor
How confident are you that you can manage most of your health problems?	Confident Somewhat Not very confident Don't have any health concerns
What are your biggest concerns about managing your health? Check all that apply	<ul style="list-style-type: none"> <input type="radio"/> None <input type="radio"/> I live in an unsafe environment <input type="radio"/> Transportation to appointments <input type="radio"/> Financial difficulty in paying for services/medicines <input type="radio"/> I have difficulty taking or remembering my medicines <input type="radio"/> Difficult reading or understanding instructions <input type="radio"/> I am lonely or don't have a lot of support at home <input type="radio"/> I fall a lot at home
How many times in the last 6 months have you been to the emergency room?	0 1-2 3-4 5+ I don't know
How many times in the last 6 months have you been admitted to the hospital?	0 1-2 3-4 5+ I don't know
Please list any new healthcare providers you have seen since your last visit with us.	
How many different prescriptions are you taking?	0-3 4-6 7-10 10+ I don't know
Please list any new medicines you have started since your last visit with us.	
Have you had any problems with your vision?	Yes No
Have you had any problems with your hearing?	Yes No
Do you or your family members have any concerns about your memory?	Yes No
Please list any updates to your Family Medical History (family conditions that your doctor may not know about):	

TOBACCO, ALCOHOL, and SUBSTANCE USE

Do you use any tobacco products? (Cigarettes, chew, snuff, pipes, cigars)	Yes No
If so, are you interested in quitting tobacco?	Yes No I don't use tobacco
Do you use any illegal drugs or take any prescription medications that have not been prescribed to you?	Yes No
How many times in the past year have you had 4 or more drinks in a day?	1-2 3-4 5+ I don't drink

NUTRITION

Do you follow any special diet? (low sodium/cholesterol/fat?)	Yes No
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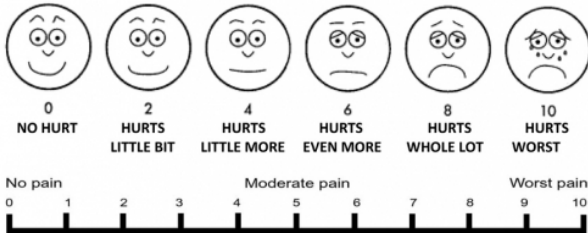
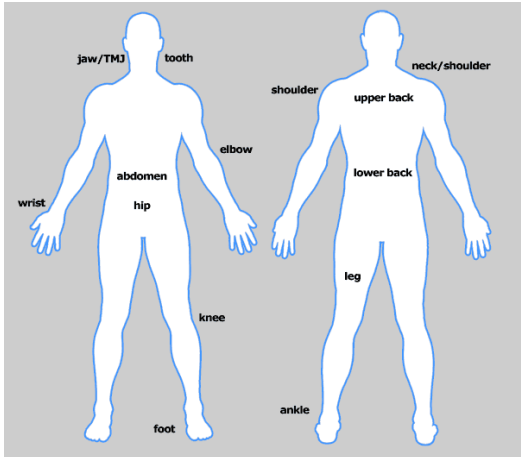
Do you use any dietary supplements, including meal replacement drinks?	Yes No
In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?	0 1-2 3-4 I don't know
PHYSICAL ACTIVITY	
How many days a week do you exercise?	0 1-2 3-4 5+ I don't know
How intense is your exercise?	Light Moderate Heavy Very Heavy I don't know I don't exercise
SLEEP	
How many hours of sleep do you usually get?	0-3 4-6 7-10 10+ I don't know
Do you snore, or has anyone told you that you snore?	Yes No I don't know
In the past 7 days, how often have you felt sleepy during the day?	Often Sometimes Almost Never Never
Have you ever been diagnosed with Sleep Apnea or other sleep disorders?	Yes No I don't know
Are you currently using or have you used C-PAP/Bi-PAP?	Yes No

FUNCTIONAL STATUS ASSESSMENT	
Activities of daily living (ADL's) - Please circle those that apply.	
Which of the following can you do on your own without help?	Bathe Dress Eat Walk Use the restroom Transfer in/out of chairs, etc. None
Does someone help you at home? If yes, please provide Caregiver Name:	Yes No Spouse Children Other: Aide/Caregiver #:
Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experienced leaking of urine?	Yes When cough/sneeze No I don't know
Instrumental activities of daily living (IADL's) - Please circle those that apply.	
Which of the following can you do on your own without help?	Shop for groceries Use the telephone Housework Handle finances Drive/Use public transportation Take Medications Make meals None

HOME/SAFETY

What is your housing situation like? Check all that apply	<input type="checkbox"/> Live with one or more children or dependent <input type="checkbox"/> Live in an assisted living facility <input type="checkbox"/> Live in a nursing facility <input type="checkbox"/> Live alone <input type="checkbox"/> I have housing today, but I am worried about losing housing in the future <input type="checkbox"/> I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
Do you have a problem with any of the following at your home? Check all that apply	<input type="checkbox"/> Bug infestation <input type="checkbox"/> Mold <input type="checkbox"/> Lead paint or pipes <input type="checkbox"/> Inadequate heat <input type="checkbox"/> Oven or stove not working <input type="checkbox"/> No or not working smoke detectors <input type="checkbox"/> Water leaks <input type="checkbox"/> None of the above
Do you feel safe in your home?	Yes No
Does your home have working smoke alarms?	Yes No I don't know
Do you have throw rugs on your floor(s)?	Yes No
Do you have handrails in the bathroom?	Yes No
Do you have proper lighting in your home?	Yes No
Do you have handrails for the stairs?	Yes No I don't have stairs
Do you fasten your seatbelt in vehicles?	Yes No I don't ride in vehicles

PAIN ASSESSMENT

In the past 2 weeks, how often have you felt pain?	Almost all of the time Most times Sometimes Almost never Never
Where is the pain? Mark all areas in which pain is present. Rate your pain on the following scale: 	
How do you treat the pain?	Medication Rest Heat/Cold Therapy I don't treat my pain

If you take opioids (hydrocodone, oxycodone, etc) have you been provided information on non-opioid treatment options for pain?	Yes	No
Have you ever misused opioids or have risk factors for misuse of opioids?	Yes	No
If you take opioids, have you been offered a referral to a Pain Specialist?	Yes	No
RISK FOR FALLING		
Which of these assistive devices do you use? Please circle all that apply	Cane Crutches	Walker Other
	Wheelchair None	
Do you have trouble with your balance?	Yes	No
Have you fallen 2 or more times or have had a fall with injury in the past year?	Yes	No
Are you afraid of falling?	Yes	No
Do you have any amputations?	Yes	No If yes, where?
SENSORY ABILITY (please circle all that apply)		
Do you have problems with vision? Eye Doctor name:	Yes	No If yes, please identify: Legally blind Cataracts Diabetic Retinopathy Other:
Do you use eyeglasses or contacts?	Yes	No
Do you have problems with your hearing? ENT/Hearing Specialist name:	Yes	No If yes, please identify: Partial hearing loss Deaf TTY Other:
Do you use hearing aids or other devices to help you hear?	Yes	No
SOCIAL/EMOTIONAL SUPPORT (please circle all that apply)		
Which of the following applies to you? Please check all that apply	<ul style="list-style-type: none"> • I have a supportive family • I have supportive friends • I participate in church, clubs, or other groups • None 	
How often do you get out and meet with family and friends?	Often	Sometimes Almost Never Never
Describe your current living situation.	Alone Assisted Living Facility	Spouse Children. Homeless Don't have a stable home
ADVANCE DIRECTIVES		
Does your family or friends know what you want in an emergency situation or if you could not speak for yourself? Check all that apply <i>If you have any of the following, it would be helpful to have a copy provided to us for your medical record.</i>	<ul style="list-style-type: none"> • Yes, I have a living will • Yes, I have a health care power of attorney • Yes, I have a MOLST • Yes, I have a POLST • Yes, I have completed 5 wishes • No 	
Would you like more information?	Yes	No Unsure