Name_____Date of Birth_____ Today's Date_____

Medicare Wellness Visit Patient Questionnaire

Please complete this questionnaire before your visit and bring it with you along with all of your current medications.

Advance Care Planning (*See page7 for more details)*

	No	Yes*	Don't Know
Do you have an advance directive or living will?			
Do you have a healthcare proxy or surrogate decision maker?			

**If yes, please bring a copy for your chart!*

Provider List

- If this is your first Medicare Wellness visit, please list the providers who care for you.
- If this is not your first Medicare Wellness visit, please list new providers since your last visit.
- Please include doctors and other suppliers of care like personal care assistant, home health aide, adult day care, home delivered meals, etc.

Provider Name	Provider Location	Provider Phone

How have you been feeling?

In the past two weeks:	Not at All	Several Days	More than half the days	Nearly every day
Have you been bothered by little pleasure in doing things?				
Have you been bothered by feeling down depressed or hopeless?				
Trouble falling or staying asleep, or sleeping too much?				
Do you feel tired or have too little energy?				
Poor appetite or overeating?				
Feeling bad about yourself or that you are a failure or have let yourself or your family down?				

Name_____Date of Birth_____ Today's Date_____

In the past two weeks:	**Not at All**	**Several Days**	**More than half the days**	**Nearly every day**
Trouble concentrating on things, such as reading the newspaper or watching television?				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual?				
Thoughts that you would be better off dead, or of hurting yourself?				

	Hardly Ever	**Sometimes**	**Often**
How often is stress a problem for you in handling your health, finances, family or social relationships?			
In the past 7 days, how often have you felt angry?			
How often do you feel you lack companionship?			
How often do you feel left out?			
How often do you feel isolated from others?			
In the past 7 days, how much pain have you felt?			

	No	**Yes**
Do you have concerns about your memory?		
Have family or friends been concerned about your memory?		
Do you have concerns about sex?		
Do you have problems with your teeth or gums?		
Do you have dentures?		
Do you see a dentist?		
Does anyone have concerns about your hearing?		

Vitamins- check the ones you take

	None		Vitamin D
	Calcium		Other:
	Multi-vitamin		

Diet

- How many fruits and vegetables do you eat on most days? _____
- How many fried foods do you eat on most days? _____
- How many 8 oz. glasses of fruit juice or sweetened beverages do you drink on most days? _____
- Within the past 12 months, I/we have worried about whether our food would run out before we had enough money to buy more: *Circle one:* Often Sometimes Never
- Within the past 12 months, the food I/we bought just didn't last and we didn't have money to get more: *Circle one:* Often Sometimes Never

Name_____Date of Birth_____ Today's Date_____

Functioning at Home

	Able to	Not able to	Find it difficult to
Dress yourself			
Feed yourself			
Toilet yourself			
Groom yourself			
Bathe yourself			
Handle your finances			
Obtain and take your medicines			
Get in and out of a car			
Walk 1-4 blocks			
Walk 5-9 blocks			
Walk 10 or more blocks			
Go down steps			
Go up steps			
Kneel			
Put on socks and shoes			
Shop for yourself			
Prepare your own food			
Do your housekeeping			
Do your laundry			
Use a telephone			

What transportation do you use? _____
(for example: taxi, drive your car, family drives you, friend drives you, etc.)

Home Safety

	No	Yes
Do you have smoke detectors in your home?		
Do you have firearms in your home?		
Do you use a seat belt when in a vehicle?		

Falls

	No	Yes
Did you fall in the last year?		
If so, did the fall(s) result in injury?		
Do you use a cane or walker?		
Do you have trouble with balance?		

How would you describe your physical activity level?

- □ **None -** You are not physically active and spend most of your time sitting or resting.
- □ **Low** - You do light physical activity (able to have a normal conversation while moving).
- □ **Medium** - You do some moderate physical activity (breathing harder, more difficult to talk while moving) per week.
- □ **High** - You do 150 or more minutes per week of moderate physical activity, or 75 or more minutes per week of vigorous physical activity (somewhat breathless, very difficult to talk while moving).

Name_____Date of Birth_____ Today's Date_____

Alcohol

- How often do you have a drink containing alcohol?

Circle one: Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week

- How many standard drinks containing alcohol do you have in a typical day when you drink?

Circle one: None 1 or 2 3 or 4 5 or 6 7 to 9 10 or more

- How often do you have 6 or more drinks on one occasion?

Circle one: Never Less than monthly Monthly Weekly Daily or almost daily

Tobacco and Vaping

	No	**Yes**	**If yes, what kind?**	**If yes, number per day?**	**Former User- age when quit**
Do you use tobacco?					
Do you vape or use electronic cigarettes?					

Other Medications

	No	**Yes**
Do you take opioids (narcotics)?		
Do you take drugs you obtained elsewhere?		

Medical History Update

	No	**Yes**	**Details if Yes**
Illnesses since last visit			
Injuries since last visit			
Hospital stays since last visit			
Specialists since last visit			
Operations since last visit			

Family History Update

Write new health problems since your last visit for your:

- Parents: _____
- Siblings: _____ ____No siblings
- Children: _____ ____No children

Name_____Date of Birth_____ Today's Date_____

Advance Directive Explanation

An advance directive is an important legal document for all adults to have. It serves as a guide for your family and healthcare team to follow if a life-threatening event were to happen. Developing a guide keeps you in charge when it comes to decisions about medical treatment—even when you're no longer capable of making those decisions. This kind of planning also shows compassion for family and friends. When loved ones are left guessing, too often the result is guilt, uncertainty, and arguments. By making your wishes known, you can help your loved ones feel more comfortable with your chosen course of care. If you have an advance directive or have assigned a healthcare proxy, our office would like to have a copy of that information in your health record.

- An advance directive, also known as a living will, tells medical professionals and your family which medical treatments you want to receive or refuse—and under what conditions. It only goes into effect if you meet specific medical criteria and are unable to make decisions.
- A healthcare proxy, also known as surrogate decision maker or health care power of attorney, allows you to appoint someone to make healthcare decisions for you any time you're unable to do so. Most people choose trusted family members or friends who are comfortable talking to doctors. This is different from a regular power of attorney, which only covers financial matters.