

# Medicare Annual Wellness Questionnaire

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Please list the Name and Specialty of all your doctors:


Please list all of your medications with dosage:


- |  |     |    |
|--|-----|----|
| Have any of your close relatives had any health changes?   | YES | NO |
| Has your mood changed?   | YES | NO |
| Are you worried about your memory?   | YES | NO |
| Have you had any recent immunizations?   | YES | NO |
| Are there any preventive tests you have done recently<br>(Such as: lab tests, mammograms, x-rays)                                    | YES | NO |
| Do you have a living will or advance directive?<br>(If YES, please bring a copy of it with you)                                      | YES | NO |
| Can you get places out of walking distance without help?<br>(For example, can you travel alone by bus, taxi, or drive your own car?) | YES | NO |
| Can you shop for groceries or clothes without help?  | YES | NO |
| Can you prepare your own meals?  | YES | NO |
| Can you do your own housework without help?  | YES | NO |
| Can you handle your own money without help?  | YES | NO |
| Do you need help eating, bathing, dressing, or getting around your home?   | YES | NO |

# Annual Questionnaire

Once a year, all our patients are asked to complete this form because these factors can affect your health as well as medications you may take.

Please help us provide you with the best medical care by answering the questions below.

## Alcohol

One Drink Equals:



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12 oz. of beer  
(about 5% alcohol)

8-9 oz. of malt liquor  
(about 7% alcohol)

5 oz. of wine  
(about 12% alcohol)

1.5 oz. of hard liquor  
(about 40% alcohol)

MEN: How many times in the past year have you had  
5 or more drinks in a day?

None

1 or More

WOMEN: How many times in the past year have you had  
4 or more drinks in a day?

None

1 or More

## Drugs

Recreational drugs include:

Methamphetamines (speed, crystal), Cannabis (marijuana, pot)

Inhalants (paint thinner, aerosol, glue), Tranquilizers (Valium)

Barbiturates, Cocaine, Ecstasy, Hallucinogens (LSD, mushrooms)

Narcotics (heroin)

How many times in the past year have you used a recreational  
drug or used a prescription medication for nonmedical reasons?

None

1 or More

## Mood

During the past two weeks, have you been bothered by  
little interest or pleasure in doing things?

No

Yes

During the past two weeks, have you been bothered by  
feeling down, depressed, or hopeless?

No

Yes

1) During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

- Not at all
- Slightly
- Moderately
- Quite a bit
- Extremely

2) During the past 4 weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

- Not at all
- Slightly
- Moderately
- Quite a bit
- Extremely

3) During the past 4 weeks, how much bodily pain have you generally had?

- No pain
- Very mild pain
- Mild pain
- Moderate pain
- Severe pain

4) During the past 4 weeks, was someone available to help you if you needed and wanted help?

- Yes, as much as I wanted
- Yes, quite a bit
- Yes, some
- Yes, a little
- No, not at all

5) During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?

- Very heavy
- Heavy
- Moderate
- Light
- Very light

6) During the past 4 weeks, how would you rate your health in general?

- Excellent
- Very good
- Good
- Fair
- Poor

7) How have things been going for you during the past 4 weeks?

- Very well – could hardly be better
- Pretty good
- Good and bad parts about equal
- Pretty bad
- Very bad – could hardly be worse

8) Are you having difficulties driving your car?

- Not applicable, I do not use a car
- No
- Sometimes
- Yes, often

9) Do you always fasten your seat belt in a car?

- Yes, usually
- Yes, sometimes
- No

10) Are you a smoker?

- No
- Yes, and I might quit
- Yes, but I'm not ready to quit

11) Do you exercise for 20 minutes, 3 days a week?

- Yes, most of the time
- Yes, some of the time
- No, I do not exercise this much

12) How often do you have trouble taking medicines the way you have been told to take them?

- I do not have to take medicine
- I always take them as prescribed
- Sometimes I take them as prescribed
- I seldom take them as prescribed

13) How confident are you that you can control and manage most of your health problems?

- I do not have any health problems
- Very confident
- Somewhat confident
- Not very confident

14) How often during the past 4 weeks have you been bothered by sexual problems?

- Never
- Seldom
- Sometimes
- Often
- Always

15) How often during the past 4 weeks have you been bothered by trouble eating well?

- Never
- Seldom
- Sometimes
- Often
- Always

16) How often during the past 4 weeks have you been bothered by your teeth or dentures?

- Never
- Seldom
- Sometimes
- Often
- Always

17) How often during the past 4 weeks have you been bothered by problems using the telephone?

- Never
- Seldom
- Sometimes
- Often
- Always

18) How often during the past 4 weeks have you been bothered by being tired or fatigued?

- Never
- Seldom
- Sometimes
- Often
- Always

19) How often during the past 4 weeks have you been bothered by a fall or feeling dizzy when standing up?

- Never
- Seldom
- Sometimes
- Often
- Always

20) Have you fallen 2 or more times in the past year?

- No
- Yes

21) Are you afraid of falling?

- No
- Yes

22) Have you been give any information to help you with hazards in your house?

- No
- Yes