{Patient Label}

Medicare Annual Wellness Questionnaire

Outside of Mtn. View Family Practice, list all physicians/providers involved in your healthcare:

Allergy		Nephrology (kidney)		Podiatry (feet)	
Cardiologist (Heart)		Neurology (brain)		Pain	
Dermatology (skin)		OB/GYN		Pulmonology (lungs)	
Ear/Nose/Throat (ENT)		Oncology (Cancer)		Rheumatology	
Gastroenterology (digestive)		Ophthalmology (Eye)		Urology (bladder)	
Endocrinology (diabetes/thyroid)		Physical Therapy		Other	

Please list all of your medications, including herbs and supplements with dosage:

Name	Dose	Name	Dose	Name	Dose

Activities of Daily Living:

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
Is someone available to help you if you needed or wanted help?	YES	NO
Are you having difficulties driving your car? ☐ I do not drive a car	YES	NO
Do you always fasten your seat belt in a car?	YES	NO

Health:

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

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

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

☐ I have no health problems ☐ Very confident ☐ Somewhat confident ☐ Not very confident

How often do you take medicines the way you have been told to take them?

☐ I do not take medicine ☐ Always ☐ Sometimes ☐ Seldom

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

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

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

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Function and Cognition:

Are you deaf or do you have serious difficulty hearing?

☐ No ☐ Yes ☐ Don't Know

Are you blind or have serious difficulty seeing, even when wearing glasses?

☐ No ☐ Yes

Do you have serious difficulty walking or climbing stairs?

☐ No ☐ Yes

Do you have difficulty dressing or bathing?

☐ No ☐ Yes

Do you have serious difficulty concentrating, remembering or making decisions?

☐ No ☐ Yes

Do you have serious difficulty learning how to do things most people your age can learn?

☐ No ☐ Yes

Using your usual language, do you have serious difficulty communicating?

☐ No ☐ Yes

Do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

☐ No ☐ Yes

Do you have serious difficulty with: mood, intense feelings, controlling your behavior, or experience delusions/hallucinations?

☐ No ☐ Yes

Do any other conditions or functional difficulties impact your daily living, other than those listed above?

☐ No ☐ Yes – List additional:_____

Do you use any assistive devices as part of daily living?

☐ No ☐ Yes – List device(s): _____

Falls:

Have you fallen in the last six months?

☐ No ☐ Yes – If yes, how many times in the last year? _____ Were you injured? _____

Are you afraid of falling?

☐ No ☐ Yes

Have you been given any information to help you with hazards in your house?

☐ No ☐ Yes

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

Pain:

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

☐ No pain ☐ Very mild pain ☐ Mild pain ☐ Moderate pain ☐ Severe pain

{Patient Label}

Alcohol:

One Drink Equals:

12 oz. beer **8-9 oz. malt liquor** **5 oz. wine** **1.5 oz. liquor(one shot)**

How many times in the last year have you had 4 or more drinks in a day? None 1 or more

Drugs:

Recreational drugs include:
~ Cannabis: (marijuana, pot) ~ Narcotics (heroin) ~ Cocaine ~ Ecstasy
~ Inhalants:(paint thinner, aerosol, glue) ~ Methamphetamines:(speed, crystal)
~ Hallucinogens (LSD, mushrooms) ~ Barbiturates ~ Tranquilizers (valium)

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

Social Determinants of Health:

Within the last 12 months, have you worried that your food would run out before you got money to buy more? Never Sometimes Often

Within the last 12 months, did the food you bought just not last and you didn't have money to get more? Never Sometimes Often

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In the last 12 months, has lack of transportation kept you from medical appointments or getting medications? No Yes

In the last 12 months, has lack of transportation kept you from meetings, work, or getting things needed for daily living? No Yes

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In the last 12 months, was there a time when you were not able to pay the mortgage or rent on time? No Yes

Are you now or at any time in the past 12 months been homeless or living in a shelter? No Yes

Exercise:

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

How many days a week do you exercise on average?

☐ 0 ☐ 1-2 ☐ 2-3 ☐ 3-4 ☐ 5 or more

Average duration: ☐ Less than 30 min each time ☐ 30 min each time ☐ More than 30 min each time

Oral Health:

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

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

When was your last oral exam and x-rays? _____

Urinary:

During the last 6 months, have you leaked urine (even a small amount)?

☐ Yes ☐ No – Skip next question

When you leaked urine during the last 6 months, were you: (check all that apply)

☐ performing some physical activity, such as coughing, sneezing, lifting or exercise.

☐ having the urge or feeling to empty your bladder, but couldn't get to the toilet fast enough.

☐ without physical activity and without a sense of urgency

Advanced Care Planning:

Do you have a current POLST?	YES	NO
Do you have a living will or advance directive?	YES	NO

**If YES to either, please bring a copy with you