Sutter Health

# Medicare Annual Wellness Visit Questionnaire

**Name:** _____ **Date of Birth:** _____ **Today's Date:** _____

**What over the Counter Medications are you taking, including vitamins and supplements?**

| Medications/Vitamins/Supplement | Reason |
|---|---|
| | |
| | |
| | |

**What other physicians or providers do you see, and for which problems?**

| Specialist | Problem |
|---|---|
| | |
| | |

**Where do you get your medical supplies? (Diabetes, ostomy supplies, etc)**

| Medical Supplier | Problem |
|---|---|
| | |
| | |

**How do you rate your health?** (Circle one) Excellent Good Fair Poor

**Hearing/Vision Evaluation:**

| | | |
|---|---|---|
| Do you have trouble hearing the television or radio when others do not? | Yes | No |
| Do you have to strain or struggle to hear or understand conversations? | Yes | No |
| Do you have trouble seeing, even with glasses? | Yes | No |

**Functional Evaluation:**

| | | | | | |
|---|---|---|---|---|---|
| Do you have trouble walking? | Yes | No | Do you need help with shopping? | Yes | No |
| Do you need help climbing stairs? | Yes | No | Do you need help with preparing meals? | Yes | No |
| Do you need help with bathing? | Yes | No | Do you need help with housework? | Yes | No |
| Do you need help with dressing? | Yes | No | Do you need help with laundry? | Yes | No |
| Do you need help with telephone use? | Yes | No | Do you need help with taking medications? | Yes | No |
| Do you need help with transportation? | Yes | No | Do you need help with managing money? | Yes | No |
| Do you have trouble concentrating, remembering or making decisions? | | | | Yes | No |

**Depression Questionnaire:**

| | | |
|---|---|---|
| Over the past 2 weeks, have you felt down, depressed or hopeless? | Yes | No |
| Over the past 2 weeks, have you felt little interest or pleasure in doing things? | Yes | No |

**Home Safety:**

| | | |
|---|---|---|
| Do you have a working smoke alarm in your home? | Yes | No |
| Does your home have loose rugs in the hallway? | Yes | No |
| Does your home have poor lighting? | Yes | No |
| Does your home have grab bars in the bathroom? | Yes | No |
| Does your home have handrails on the stairs? | Yes | No |
| Do you live alone? | Yes | No |
| In the past 12 months, have you fallen? | Yes | No |
| In the past 6 months, have you experienced leaking of urine? | Yes | No |

**Advance Directive:**

| | | |
|---|---|---|
| Do you have an Advance Directive? | Yes | No |