Please fill out and bring this form with you for your appointment on:

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MEDICARE WELLNESS QUESTIONAIRE

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Name ________________________________ D.O.B.___________ Date________________

Thank you for scheduling your Medicare Annual Wellness Visit. Medicare recommends that you have a wellness visit every year. This visit is important as we discuss your health, safety, and well-being and devise a treatment plan for future wellness. However, often during these visits we must address your significant medical conditions. This may incur an additional charge to your insurance. This charge may be assessed as a copay or applied towards your deductible.

"Medicare covers an Annual Wellness Visit providing Personalized Prevention Plan Services for beneficiaries. [The Medicare] Annual Wellness Visit is not a routine physical checkup… Medicare does not cover routine physical examinations. The Annual Wellness Visit does not include any clinical laboratory tests; … other medically necessary tests [may be provided] on the same date of service as an Annual Wellness Visit. The deductible and coinsurance/copayment apply for these other medically necessary services."

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STEADI Fall Risk:

1. Have you fallen in the past year? ……………………………………………….………… Yes No
2. Do you use or have been advised to use a cane or walker to get around safely? ………… Yes No
3. Do you sometimes feel unsteady while walking? ………………………………………… Yes No
4. Do you steady yourself by holding onto furniture when walking at home?……………… Yes No
5. Do you worry about falling? …………………………………………………………… Yes No
6. Do you need to push with your hands to stand up from a chair? ………………………… Yes No
7. Do you have trouble stepping up onto a curb? ………………………………………….. Yes No
8. Do you often rush to the toilet?……………………………………………………… Yes No
9. Have you lost some feeling in your feet? ……………………………………………… Yes No
10. Do you take medicine that sometimes makes you light-headed or more tired than usual? Yes No
11. Do you take medicine to help you sleep or improve your mood? ………………………… Yes No
12. Do you often feel sad or depressed? …………………………………………………… Yes No

Depression Screen PHQ-2/ PHQ-9

1. Do you have little interest or pleasure in doing things?

   a) not at all **b)** several days **c)** more than half the days **d)** nearly every day

2. Are you feeling down, depressed, or hopeless?

   a) not at all **b)** several days **c)** more than half the days **d)** nearly every day

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Do you currently have an advanced medical directive or living will?... Yes No

Social/Behavioral History

Diet and Nutrition: **a)** healthy diet **b)** diet is high in salt **c)** diet is high in fat **d)** low in fiber **e)** high caloric intake **f)** high carbohydrate meals **g)** inadequate caloric intake **h)** low calcium intake

Fracture Risk: **a)** No History of fractures **b)** history of fractures **c)** recent explained fracture **d)** sudden unexplained fractures **e)** previous musculoskeletal

Physical Activity: **a)** exercise on a regular basis **b)** recent increase in physical activity **c)** good physical condition **d)** do not exercise on a regular basis **e)** decreased physical activity **f)** poor physical condition **g)** deconditioned due to sedentary lifestyle

Mental Status

Depression Risk: **a)** never feels sad, empty, or tearful **b)** feels sad, empty, or tearful **c)** loss of interest in activities **d)** significant changes in weight **e)** sleep disturbances or insomnia **f)** agitation **g)** loss of energy **h)** feelings of worthlessness or guilt **i)** thoughts of suicide **j)** history of depression **k)** history of mood disorder

Orientation: **a)** no disorientation to time **b)** no disorientation to date **c)** no disorientation to place **d)** disorientation to time **e)** disorientation to date **f)** disorientation to place

Concentration and Memory: **a)** no decreased concentrating ability **b)** no memory lapses or loss **c)** does not forget words **d)** decreased concentrating ability **e)** memory lapses or loss **f)** forget words

Speech/Motor difficulties: **a)** no speech difficulties **b)** no difficulty expressing formulated concepts **c)** no difficulty with fine manipulative tasks **d)** no difficulty writing/copying **e)** no slowed reaction time **f)** does not knock things over when trying to pick them up **g)** speech difficulties **h)** difficulty expressing formulated concepts **i)** difficulty with fine manipulative tasks **j)** difficulty writing/copying **k)** slowed reaction time **l)** knock things over when trying to pick them up

Functional Ability

Hearing: **a)** no hearing loss **b)** wears hearing aids **c)** loss of hearing in one ear only **(R) (L)** **d)** loss of hearing in both ears **e)** fluctuating **f)** getting progressively worse **g)** difficulty hearing over background noise **h)** requires TV, radio at high volume **i)** tone deafness

Vision: **a)** no vision problems **b)** wears eyeglasses **c)** total vision loss **d)** worsening **e)** briefly vision loss **f)** worse with distance **g)** worse both distance and near **h)** worse near **i)** seeing double images with fatigue **j)** blind spot(s) **k)** sudden partial vision loss **l)** slow partial vision loss **m)** increased sensitivity to glare **n)** difficulty seeing in bright light **o)** worsening depth perception **p)** blurred vision

Activities of Daily Living: **a)** able to bathe without assistance **b)** able to dress without assistance **c)** able to control urination and bowels **d)** able to feed self without assistance **e)** able to get out of chair or bed without

assistance **f)** able to groom without assistance **g)** able to go to the toilet without assistance **h)** unable to bathe without assistance **i)** unable to dress without assistance **j)** unable to control urination and bowels **k)** unable to feed self without assistance **l)** unable to get out of chair or bed without assistance **m)** unable to groom without assistance **n)** unable to go to the toilet without assistance

Instrumental Activities of Daily Living: **a)** able to do house work without assistance **b)** able to grocery shop without assistance **c)** able to manage medications without assistance **d)** able to manage money without assistance **e)** able to prepare meals without assistance **f)** able to use the phone without assistance **g)** unable to do house work without assistance **h)** unable to grocery shop without assistance **i)** unable to manage medications without assistance **j)** unable to manage money without assistance **k)** unable to prepare meals without assistance **l)** unable to use the phone without assistance

Home Safety

Do you have unsafe flooring hazards? …………………………………………………....………….. Yes No
Do you have unsafe stairs? ………………………………………………………………..……….. Yes No
Do you have unsafe gas appliances? ………………………………………………………………….. Yes No
Do you have working smoke/CO detectors? ………………………………………………………. Yes No
Do you wear seatbelts? ……………………………………………………………………………. Yes No
Do you have vision or hearing loss while driving? ……………………….……………….…………. Yes No
Do you have firearms in your home? ……………………………………...………………….. Yes No
Do you have hand bars in the bathroom/shower? ……………………………………………….. Yes No
Do you have good lighting in your home? ……………………………….………………….. Yes No
Do you use sunscreen? …………………………………..………………...………………….. Yes No
How many motor vehicle accidents have you been in? _________

Do you go to see other specialists? If so please list the name of the Doctor, the specialty, and if possible the phone number.

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Do you use any medical suppliers for medical equipment, such as Lincare and/or nursing agencies? If so, please list them

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Have you received any vaccines outside of our office? If so, please list the name of the vaccine and the date of the injection.

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