Name: _____

Date of Birth: _____

Today's Date: _____

Medicare Wellness Visit

Dear Patient,

Your Medicare benefits include an Annual Wellness Visit to assist in preventing illness or detect illness at an early stage. Your Annual Wellness Visit is a free benefit from Medicare. During this visit, the provider will:

- Concentrate on preventative medicine.
- Focus on identifying factors that may represent risk for further medical problems. The provider will work with you to reduce these risks.
- Review your medical history, medications, and confirm the names of any other medical providers you see.
- Work with you to establish a personal prevention plan in an effort to prevent or identify medical problems.

** This wellness visit is provided without any cost to you, but does not include the cost of medical treatment and is not the same as an "annual physical exam". If medical treatment is provided, your insurance may require an office co-pay be applied to the visit. If needed, a follow-up appointment will be scheduled to address any additional issues or concerns. **

_____ _____

Patient Signature Date

2023 AWV Questionnaire - Please complete the front and back
Please complete this checklist before seeing your doctor or nurse.

Patient Name:_____ DOB:_____ Today's Date:_____

Do you have any of the following: (Mark all that apply)
☐ Living Will ☐ Health Care Proxy ☐ Power of Attorney ☐ Do Not Resuscitate (DNR)

Do you need help with any of the following: (Mark all that apply)?
Dressing: ☐ Grooming: ☐ Walking: ☐ Bathing: ☐ Toilet Use: ☐
Shopping: ☐ Eating: ☐ Driving: ☐ Housework: ☐ Household Finances: ☐
Preparing Meals: ☐ Taking Medications: ☐ No Assistance needed for any of the items: ☐

Do you currently work?: ☐ No ☐ Yes

Do you exercise? ☐ No ☐ Yes
What is your physical activity level? : ☐ Very Light ☐ Light ☐ Moderate ☐ Heavy ☐ Very Heavy

Do you smoke or use tobacco products?: ☐ No ☐ Yes
If yes, would you like help quitting? ☐ No ☐ Yes

Have you been to the emergency room two (2) or more times in the last (12) months? ☐ No ☐ Yes
Have you been admitted to the hospital in the last (12) months? ☐ No ☐ Yes
Have you had any changes in thinking, remembering or making decisions? ☐ No ☐ Yes
Do you have a hearing impairment that requires special equipment?: ☐ No ☐ Yes
Are you currently in Pain? ☐ No ☐ Yes - Location:_____
In the past 12 months, have you fallen two (2) or more times?: ☐ No ☐ Yes
Do you currently use a walker, cane or other device?: ☐ No ☐ Yes
Are you currently sexually active? ☐ No ☐ Yes

How many prescription medications do you take each day? :
1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8 or more☐ ☐ Not taking medications
Please list medications and doses:

_____ _____ _____ _____
_____ _____

Do you sometimes run out of money to pay for food, rent, bills and medicine? ☐ No ☐ Yes
In general, would you say your health is: ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Depression Screening PHQ9

During the last 4 weeks, how often have you been bothered by any of the following problems	Not at all (0)	Several Days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or asleep too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure, or have let yourself or family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

Preventative Maintenance

Preventative Maintenance	Last Done (Provide Date)	Where Done and by Who? (i.e. PCP name, Walgreens)	What was performed? If not preformed, why?
FLU Vaccination			☐ Allergy ☐ Patient Refused
Pneumonia Vaccination			☐ Allergy ☐ Patient Refused
Colon Screening			☐ FOBT ☐ Cologuard ☐ Sigmoidoscopy ☐ CT Colonography ☐ Colectomy ☐ Colorectal Cancer ☐ Refused
Mammogram			☐ Breast Cancer ☐ Bilateral or two unilateral mastectomies ☐ Refused
Bone Density			☐ Refused
PSA (Prostate Screening)			☐ Refused
HbA1C			☐ Refused

See Other Side for continued questions

In an effort to help coordinate your care, please provide a comprehensive list of all providers that you see. Please indicate if they are out-of-state physicians. Specialist providers include: Cardiologists, Gastroenterologist, Endocrinologist, Ophthalmologist, Optometrists	
Provider Name:	**Specialty:**
1.	
2.	
3.	
4.	
5.	

Alcohol Screening (Please Circle)

1. How often do you have a drink containing alcohol? (0) Never (***Skip to question 9 & 10***) (1) Monthly or Less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week	6. How often during the last year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7,8 or 9 (4) 10 or more	7. How often during the last year have you had a feeling of guilt or remorse after drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
3. How often do you have six or more drinks on one occasion? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily ***-Skip to questions 9 & 10 if Total Score for questions 2 & 3 =0***	8. How often during the last year have you been unable to remember what happened the night before because you had been drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	9. Have you or someone else been injured as a result of your drinking? (0) No (2) Yes, but not in the last year (4) Yes, during the last year
5. How often during the last year have you failed to do what was normally expected from you because of drinking? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	10. Has a relative, friend, doctor or another healthcare worker been concerned about your drinking or suggested you cut down? (0) No (2) Yes, but not in the last year (4) Yes, during the last year

For Office Use Only

Height: _____ Weight: _____ BMI: _____ BP: _____/_____ P: _____

PHQ – 9 Score: _____ PHQ – 9 Interpretation: _____

Alcohol Use Disorder Identification Score/Interpretation: _____ Drug Screening Questionnaire (DAST) Score/Interpretation: _____

Additional Assessments:

GPCOG Screening Test Complete: _____ Health Risk Assessment Complete: _____ Opioid – Patient/Physician Agreement: _____

Information/Education Provided:

Referrals Made/Provided: