Name: _____ Date of Birth: _____

If you require assistance in filling out this form, please indicate who is helping you with it:

Name of person: _____ Relationship: _____

How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Your Healthcare Team: (OR Providers and Suppliers of Your Medical Care):
Please list all providers and suppliers of your medical care such as primary care physicians, specialty physicians (e.g., eye doctor, cardiologist/heart doctor), and therapists). Please use back of page for additional team members.

Team Member	**Role**	**Contact Information**
Family/Primary Care Doctor	Oversees all your healthcare needs	Name: Phone Number:
Cardiologist	Monitors your heart	Name: Phone Number:
Ophthalmologist/ Optometrist	Examines your eyes to prevent damage	Name: Phone Number:
Endocrinologist	Manages diabetes and blood sugar control	Name: Phone Number:
Dentist	Helps to keep your teeth and gums in good condition	Name: Phone Number:
Nephrologist	Monitors your kidney health	Name: Phone Number:
Gastroenterologist	Manages digestive health and performs colonoscopies	Name: Phone Number:
Other Healthcare team members	**Role**	**Specialty**
		Name: Phone Number:
		Name: Phone Number:

Medicare Annual Wellness Visit/Health Information Questionnaire

Your past medical history:

Medical Problems	Past Surgeries and Injuries	Ongoing Regular Treatments (i.e., cancer, anemia, etc.)
☐ Arthritis		
☐ Asthma or COPD		
☐ Cancer		
☐ Diabetes		
☐ Heart Problems		
☐ High Blood Pressure		
☐ Other		

Your family medical history:

Mother	Father	Brother	Sister
☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer
☐ Heart Problems	☐ Heart Problems	☐ Heart Problems	☐ Heart Problems
☐ High Blood Pressure	☐ High Blood Pressure	☐ High Blood Pressure	☐ High Blood Pressure
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
☐ Depression	☐ Depression	☐ Depression	☐ Depression
☐ Dementia	☐ Dementia	☐ Dementia	☐ Dementia
☐ Other	☐ Other	☐ Other	☐ Other
☐ None of the above	☐ None of the above	☐ None of the above	☐ None of the above

Current Medications:
Please list all current medications you take, including over-the-counter medications, eye drops, vitamins and supplements. Please use the reverse side of the page if you take more medications/supplements.

Medication name	Dose/amount	How often is it taken?
Do you take your medications in the way you were told to take them?		☐ Almost always ☐ Sometimes ☐ Rarely ☐ Almost never

Do you have any allergies? ☐ Yes ☐ No

List: _____

Preventive Screening/Services:
Please list the dates of your most recent screening/preventive health procedures, if known. If unknown please leave blank.

Screenings/Services	Date Received
Flu Shot	
Pneumonia Shot 1 PVC13	
Pneumonia Shot 2 PVC23	
Tetanus Shot	
Shingles Shot	
Hepatitis C-Screening (Born between 1945-1965)	

Screenings/Services	Date Received
Colorectal Cancer	
• Stool sample/FIT test	
• Flexible sigmoidoscopy	
• Colonoscopy	
Cardiovascular screening (total cholesterol, LDL, HDL)	

Females Only:

Services/Screenings	Date Received
Mammogram	
Pap Smear/Pelvic Exam	
Bone Density Scan	

Males Only:

Screenings/Services	Date Received
Abdominal Aortic Aneurysm Screening (Ultrasound of the abdomen)	

Your Mood (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	
Little interest or pleasure in doing things?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
Feeling down, depressed, or hopeless?	☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Your Social and Emotional Support:

How often do you get the social and emotional support you need?	☐ Almost always ☐ Sometimes ☐ Rarely ☐ Almost never
Do you have someone available to help you on an ongoing basis if you are sick and need help?	☐ Yes ☐ No ☐ For a short time

Your Activities of Daily Living:

Can you get to places that are not walking distance without help? (Example by taking a bus, taxi, or driving your own car)	☐ Yes	☐ No
Can you go grocery or clothing shopping without someone's help?	☐ Yes	☐ No
Can you prepare your own meals without someone's help?	☐ Yes	☐ No
Can you do your own housework without help?	☐ Yes	☐ No
Can you handle your own money without help	☐ Yes	☐ No
Can you use the telephone without someone's help?	☐ Yes	☐ No
Are you able to manage your medications without help?	☐ Yes	☐ No
Can you take care of personal care needs, such as eating, bathing, dressing and getting around the house without help?	☐ Yes	☐ No

Vision/Hearing

Do you have trouble with your vision?	☐ Yes	☐ No
Do you have trouble with your hearing?	☐ Yes	☐ No

Home Safety

Do you feel safe in your current living situation?	☐ Yes	☐ No
Have you been given any information about how to avoid safety hazards in your home?	☐ Yes	☐ No
Does your home have any of the following? • Grab bars in the bathroom	☐ Yes	☐ No
• Hand rails on stairs	☐ Yes	☐ No
• Good/adequate lighting	☐ Yes	☐ No

• Secured/taped down rugs	☐ Yes ☐ No

Mobility/Falls

Have you fallen in the past year? If YES to above, how many times did you fall? _____	☐ Yes ☐ No
Were you injured [if you fell]?	☐ Yes ☐ No
Do you ever feel unsteady when standing or walking?	☐ Yes ☐ No
Do you worry about falling?	☐ Yes ☐ No
Do you use a cane or walker?	☐ Yes ☐ No

Pain/Fatigue

Do you have trouble sleeping?	☐ Almost never ☐ Sometimes ☐ Almost always
During the past two weeks, have you had pain that interferes with performing desired activities or doing things you enjoy?	☐ Yes ☐ No
How often do you feel unusually tired?	☐ Almost never ☐ Sometimes ☐ Almost always

Diet/Exercise

How would you rate your diet? (e.g., enough servings daily of fruits and vegetables, lean meats etc.)	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Do you exercise 20 minutes a day, three or more days a week?	☐ Yes ☐ No

Tobacco and Alcohol Use

Do you currently smoke? (includes cigarettes, cigars, pipes, electronic cigarettes)	☐ Yes ☐ No
Males Only: How many times in the past year have you had 5 or more drinks in one day?	_____ times
Females Only: How many times in the past year have you had 4 or more drinks one day?	_____ times

Hospitalizations

Have you been admitted to the hospital within the last 12 months?	☐ Yes ☐ No
If yes, please list the name of the hospital and the dates you were in the hospital 1.	
2.	
3.	
4.	

Advance Care Directive/Living Will

Do you have an Advance Care Directive or Living Will?	☐ Yes ☐ No
If yes, who has a copy of it? 1.	
2.	
3.	
4.	

For Office Use Only:		
Date of Visit:	Provider Seen:	Date of Last AWV, if any::
Type of Wellness Exam:	☐ G0438 AWV, initial visit	☐ G0439 AWV, subsequent visit

Subsequent AWV – annually at least 12 months after initial AWV