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FAMILY CARE

Annual Medicare Wellness Questionnaire

Toady's Date: _____

Patient Name: _____ **DOB**: _____

Please complete this questionnaire before seeing your provider. The answers to your questions will help us provide you with the care you deserve to support your wellbeing and quality of life.

Have you ever had a Medicare Wellness Exam? **YES** or **NO**

If yes, has it been 12 months since your last one? **YES** or **NO**

Please circle what best describes you:

Diet & Nutrition:

Healthy diet

Diet is high in fat, low in fiber

High caloric intake

High carb meals

Diet high in salt

Low calcium intake

Nonsmoker

Former smoker, ____ years since quit

Current every day smoker

_____ Packs Per Day

Alcohol use per week:

NONE 1-3 drinks 4-6 drinks 7 or more drinks

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Fracture Risk:

No history of fractures	History of fractures
No sudden unexplained fractures	Sudden unexplained fractures

Physical Activity:

Exercises regularly	Does not exercise regularly
Good physical condition	Poor physical condition

Depression Risk:

I never feel sad or tearful	I feel sad &/or tearful at this time
No loss of interest	I have a loss of interest in my activities
No history of depression	History of depression

Orientation:

No disorientation	Disorientation to: time, date, place

Concentration & Memory:

No decreased concentration	Decreased concentration
No memory lapses or loss	Memory lapses or loss

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Speech/Motor difficulties:

No speech difficulties

Speech difficulties

No difficulty with fine motor tasks

Difficulty with fine motor tasks

Functional Ability:

No loss of hearing

Loss of hearing: one ear/both ears

Wears hearing aids

Worsening vision

No vision problems

Total vision loss

Last eye exam: _____

Activities of Daily Living:

Able to bath/dress self

Unable to bath/dress without help

Able to control bowel/bladder

Loss of bowel/bladder control

Able to manage medications

Unable to manage medications

Able to prepare own meals

Unable to prepare own meals

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Fall Risk Assessment:

No fall in the past year	Fall(s) _____ in the past year
No dizziness/vertigo	Dizziness/vertigo or fear of falling

Home/Self-Safety:

No unsafe floor hazards (rugs, clutter)	unsafe floor hazards (throw rugs, cluttered floor area)
Good lighting in home	Poor lighting in home
Working smoke detectors	No smoke detectors
No driving problems	Concerns regarding driving
Wears seatbelt	Does not wear seatbelt

I have had an ER visit/ hospitalization within the past 6 months

Medical Legal Documents:

-Medical Power of Attorney: someone to make medical decisions for you in the event you are unable to
-Living Will/Advance Directive: documents that make your healthcare wishes known

I have a Medical Power of Attorney	I do NOT have a Medical Power of Attorney
I have a Living Will/ Advance Directive	I do NOT have a Living Will/Advance Directive

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Pain Assessment:

None Mild (0-4) Moderate (4-5) Severe >5

Location of pain: _____

Controlled with medication: **YES** or **NO**

Please specify: _____

Do you have any new specialists that we need to add to your care team?

1._____ 3. _____

2. _____ 4. _____

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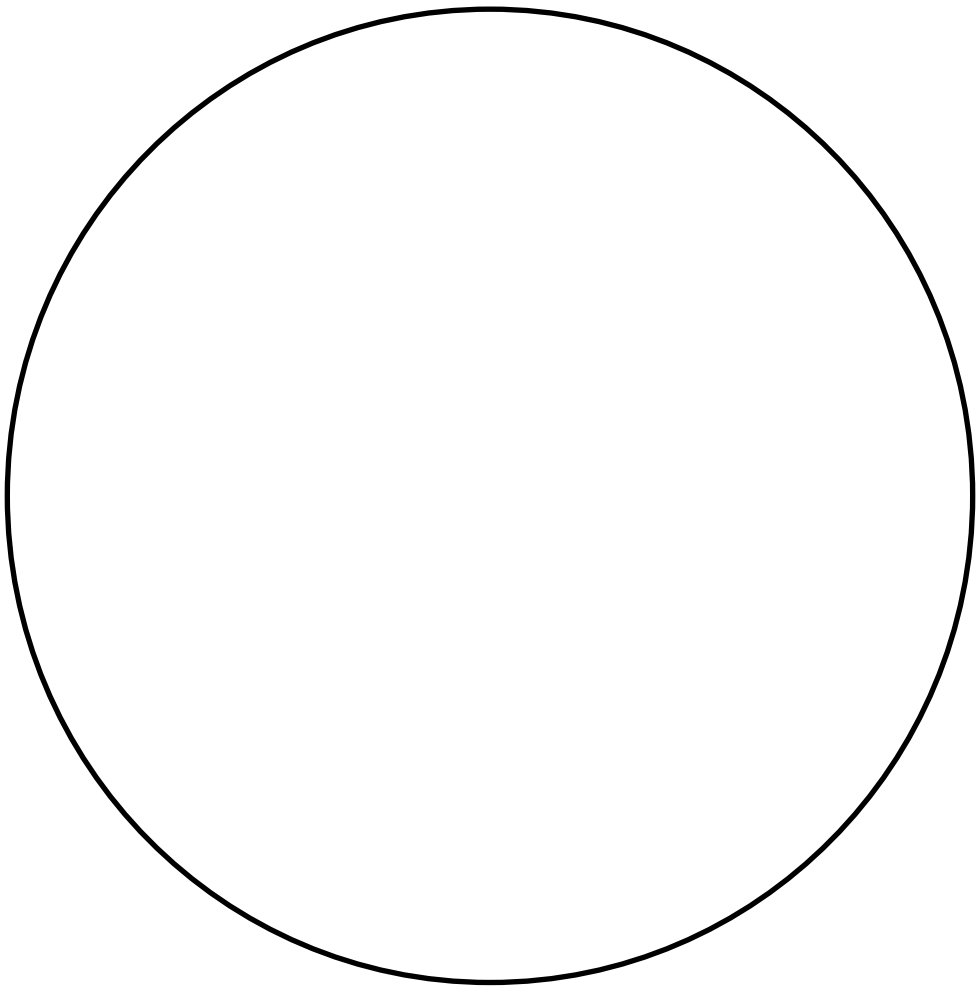
CLOCK DRAW TEST:

1. Inside the circle, please draw the hours of a clock as they normally appear.

2. Place the hands of the clock to represent the time: “ten minutes after eleven o’clock”



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