Medicare Annual Wellness Visit Questionnaire

GulfView Medical Institute
A new approach to health.

PATIENT DEMOGRAPHICS

Date: _____

Name: _____ (LAST) _____ (FIRST) _____ (MIDDLE) Date of Birth: _____ (MM/DD/CCYY)

Home Address: _____ (STREET) _____ (APT/UNIT) _____ (CITY) _____ (STATE) _____ (ZIP)

Gender: Female Male

Home Phone: _____ Day Phone: _____ Cell Phone: _____

SS #: _____

Next of Kin *(for emergency)*: _____

Name of spouse : _____ Day Phone: _____

Referred by: _____

Insurance: Name _____ Phone # _____

Policy# _____ Group # _____

CURRENT MEDICAL PROBLEMS

List any current medical problems or conditions.

1) _____ 7) _____

2) _____ 8) _____

3) _____ 9) _____

4) _____ 10) _____

5) _____ 11) _____

6) _____ 12) _____

PAST MEDICAL HISTORY

Childhood Illnesses

1) _____ **3)** _____ **5)** _____

2) _____ **4)** _____ **6)** _____

Chronic Illnesses

1) _____ **3)** _____ **5)** _____

2) _____ **4)** _____ **6)** _____

Last Eye/Glaucoma Exam: _____

Past surgeries

Surgery	Date	Surgery	Date
1) _____	_____	**4)** _____	_____
2) _____	_____	**5)** _____	_____

Patient Name: _____ **Date of Birth:** _____

PAST MEDICAL HISTORY CONT'D

List any other hospital stays

	Reason	Date		Reason	Date
1)			**4)**		
2)			**5)**		
3)			**6)**		

Physicians/practitioners you currently see

	Name / Specialty		Name / Specialty
1)		**4)**	
2)		**5)**	

ALLERGIES

List any allergies to medication, x-ray dyes, or food.

Allergy	**Reaction**

MEDICATIONS

List any medication that you currently take, including over-the-counter.

Name	Strength	Direction	Prescribed by

SOCIAL HISTORY

Do you drink alcohol?..... No Yes *If yes how much?* _____

Are others concerned about your drinking? No Yes

Diet: Balanced Vegetarian Diabetic Low salt Low fat Low carb Other: _____

Education: High school College Some College Trade school Other: _____

Do you do some form of regular exercise every day? No Yes

If yes, how much? _____

Marital Status: Married Single Divorced Widowed Other _____

Occupation: _____

List everyone in your household including pets:

Do you wear seatbelts? ..... No Yes

Have you ever smoked or chewed tobacco? ..... No Yes *If yes, how much?* _____

Patient Name: _____ **Date of Birth:** _____

SOCIAL HISTORY CONT'D

ROUTINE TASKS: ***Please indicate if you do or do not need help performing these routine tasks***

1) Feeding yourself	No	Yes	If yes, who helps? _____
2) Getting from bed to chair	No	Yes	If yes, who helps? _____
3) Getting to the toilet	No	Yes	If yes, who helps? _____
4) Getting dressed	No	Yes	If yes, who helps? _____
5) Bathing or showering	No	Yes	If yes, who helps? _____
6) Walking across the room (includes using cane or walker)	No	Yes	If yes, who helps? _____
7) Using the telephone	No	Yes	If yes, who helps? _____
8) Taking your medicines	No	Yes	If yes, who helps? _____
9) Preparing meals	No	Yes	If yes, who helps? _____
10) Managing money (like keeping track of expenses or paying bills)	No	Yes	If yes, who helps? _____
11) Moderately strenuous housework such as doing the laundry	No	Yes	If yes, who helps? _____
12) Shopping for personal items like toiletries or medicines	No	Yes	If yes, who helps? _____
13) Shopping for groceries	No	Yes	If yes, who helps? _____
14) Driving	No	Yes	If yes, who helps? _____
15) Climbing a flight of stairs	No	Yes	If yes, who helps? _____

FAMILY HISTORY

Please list any health problems and causes of death if applicable.

	Living / Deceased	Age	Medical Problems
Father			
Mother			
Brother(s)			
Sister(s)			
Mother's father			
Mother's mother			
Father's father			
Father's mother			

Patient Name: _____ **Date of Birth:** _____

HEALTH MAINTENANCE

Please record the last year you had the following. If you do not know, leave blank.

HepB (shot)		Hearing Exam	
Flu vaccine (shot)		Hemocult	
Pneumonia vaccine (shot)		Lipid Panel	
Tetanus Diphtheria vaccine (shot)		Mammogram	
Zostavax (shot)		Nutritional Therapy	
Abdom. Aortic Aneurysm Screening		Pap Smear	
Bone Density Scan		Pelvic Exam	
Colonoscopy		Prostate Exam	
Diabetes Self Management Training		PSA Test	
Echocardiogram		Rectal Exam	
Eye Glaucoma Exam		Smoking Cessation	
Glucose			

HEARING

HEARING: ***Check NO, YES, or SOME TIMES*** *for* ***each*** *question.*

1) Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?	No	Yes	Sometimes
2) Do you sometimes feel that people are mumbling or not speaking clearly?	No	Yes	Sometimes
3) Do you experience difficulty following dialogue in the theater?	No	Yes	Sometimes
4) Do you sometimes find it difficult to understand a speaker at a public meeting or religious service?	No	Yes	Sometimes
5) Do you find yourself asking people to speak up or repeat themselves?	No	Yes	Sometimes
6) Do you find men's voices easier to understand than women's?	No	Yes	Sometimes
7) Do you experience difficulty understanding soft or whispered speech?	No	Yes	Sometimes
8) Do you sometimes have difficulty understanding speech on the telephone?	No	Yes	Sometimes
9) Does a hearing problem cause you to feel embarrassed when meeting new people?	No	Yes	Sometimes
10) Do you feel handicapped by a hearing problem?	No	Yes	Sometimes
11) Does a hearing problem cause you to visit friends, relatives, or neighbors less often than you would like?	No	Yes	Sometimes
12) Do you experience ringing or noises in your ears?	No	Yes	Sometimes
13) Do you hear better with one ear than the other?	No	Yes	Sometimes
14) Have you had any significant noise exposure during work, recreation, or military service?	No	Yes	Sometimes
15) Have any of your relatives (by birth) had a hearing loss?	No	Yes	Sometimes

Patient Name: _____ **Date of Birth:** _____

DEPRESSION SCREENING

Please write your answer in the space provided.

1) Little interest or pleasure in doing things. _____

2) Feeling down, depressed, or hopeless _____

Key:

0-*Not at all* **1**-*Several days* **2**-*More than half the days* **3**-*Nearly everyday*

FALL RISK SCREENING

Please check the appropriate answer.

1) Are you afraid of falling? No Yes

2) Have you fallen in the past year? No Yes

3) If yes, circle the circumstances surrounding the fall.

Answers:

Tripped over something

Lightheadedness or palpitations prior to

Loss of consciousness

Injured

Needed to see a doctor

Able to get up on own

ADVANCE DIRECTIVE

Do you have an Advanced Directive (living will)? No Yes

Notes: _____

_____

_____

Authorized Signature: _____ Date: _____

Reviewed by: _____ Date: _____