UW Medicine
NORTHWEST HOSPITAL & MEDICAL CENTER
AMBULATORY NETWORK

Patient Label

Medicare Annual Wellness Visit

DATE: _____

NAME: Last _____ **First** _____ **MI**_____**GENDER:** _____ **BIRTHDATE:** _____

Please complete the following questionnaire. It will allow the provider to focus on your main concerns during the visit, and allow more time for discussion.

Please list current members of your healthcare team below:

_____

_____

_____

Allergies:	**Medication or Substance**	**Reaction**
☐ No Allergies		

Current Medications:	**Label – Name**	**Dose**	**Frequency**
OR			
☐ See Attached List			

Self Assessment of Health

How do you rate your overall health the past 4 weeks? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Can you manage your overall health problems? ☐ Yes ☐ No
Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house? ☐ Yes ☐ No

Psychosocial Health

In the past two weeks, how often have you been bothered by the following? (Please circle one response per statement.)

Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feelings that caused you distress or interfered with your ability to get along socially with family or friends	Not at all	Several days	More than half the days	Nearly every day
Felt stress over health, finances, relationships or work	Not at all	Several days	More than half the days	Nearly every day

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Psychosocial Health (Continued)

Do you often get the emotional support you need	Not at all	Several days	More than half the days	Nearly every day
Body pain	Not at all	Several days	More than half the days	Nearly every day
Fatigue	Not at all	Several days	More than half the days	Nearly every day

Health and Habits

How much alcohol do you drink weekly? ☐ I did not drink alcohol in the past year
☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ more than 10 drinks
Do you eat a well-balanced diet, including protein, high fiber, fruits, and vegetables? ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No
Type of exercise_____ Frequency_____
Do you always use your seat belt in the car? ☐ Yes ☐ No
How would you describe the condition of your mouth and teeth, including false teeth or dentures?
☐ Excellent ☐ Good ☐ Fair ☐ Poor
Are you sexually active? ☐ Yes ☐ No
Do you find yourself having trouble hearing people speak? ☐ Yes ☐ No
Do you wear a hearing aid/device? ☐ Yes ☐ No
Do you have a fire extinguisher in your home? ☐ Yes ☐ No
Do you have a smoke detector? ☐ Yes ☐ No

Activities of Daily Living

In your present state of health, how much difficulty do you have with the following activities? (Please circle one response per statement.)

Preparing food and eating	None	Mild	Moderate	Severe	Complete
Bathing yourself	None	Mild	Moderate	Severe	Complete
Getting dressed	None	Mild	Moderate	Severe	Complete
Using the toilet	None	Mild	Moderate	Severe	Complete
Moving around from place to place	None	Mild	Moderate	Severe	Complete

In the past year have you fallen or had a near fall? ☐ Yes ☐ No
Do you feel safe in your home environment? ☐ Yes ☐ No

Instrumental Activities of Daily Living

In your present state of health, how much difficulty do you have with the following activities? (Please circle one response per statement.)

Shopping	None	Mild	Moderate	Severe	Complete
Using the telephone	None	Mild	Moderate	Severe	Complete
Housekeeping	None	Mild	Moderate	Severe	Complete
Laundry	None	Mild	Moderate	Severe	Complete

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Instrumental Activities of Daily Living (Continued)

Driving or using transportation	None	Mild	Moderate	Severe	Complete
Managing your own finances	None	Mild	Moderate	Severe	Complete
Taking your own medications	None	Mild	Moderate	Severe	Complete

Signs of Cognitive Impairment

Have you experienced any issues of problems with thinking? ☐ Yes ☐ No
Have any concerns been raised by family members, friends, caretakers, or others? ☐ Yes ☐ No

Cardiac Risk Factors (Check all that apply)

Smoker	☐ Yes	☐ No	Family History of Heart Disease	☐ Yes	☐ No
Obesity	☐ Yes	☐ No	Sedentary Lifestyle	☐ Yes	☐ No
Diabetic	☐ Yes	☐ No	Hyperlipidemia (High Cholesterol)	☐ Yes	☐ No
Known Heart Disease	☐ Yes	☐ No			

Screening and Preventive Services

Prevnar 13 Vaccine	☐ Yes	☐ No	When _____			
Pneumovax	☐ Yes	☐ No	When _____			
Influenza Vaccine	☐ Yes	☐ No	When _____			
Hepatitis B Vaccine	☐ Yes	☐ No	When _____			
Shingles Vaccine	☐ Yes	☐ No	When _____			
Tetanus/Tdap Vaccine	☐ Yes	☐ No	When _____			
Screening for Diabetes	☐ Yes	☐ No	When _____	Abnormal?	_____	
Screening Hepatitis C	☐ Yes	☐ No	When _____	Abnormal?	_____	
Cardiovascular Screen	☐ Yes	☐ No	When _____	Abnormal?	_____	
PSA (Men)	☐ Yes	☐ No	When _____	Abnormal?	_____	
Colorectal Cancer Screening	☐ Yes	☐ No	When _____	Abnormal?	_____	
Pap Smear and Pelvic Exam (Women)	☐ Yes	☐ No	When _____	Abnormal?	_____	
Abdominal Aortic Aneurysm Screening	☐ Yes	☐ No	When _____	Abnormal?	_____	
Mammogram Screening (Women)	☐ Yes	☐ No	When _____	Abnormal?	_____	
Bone Densitometry Screening	☐ Yes	☐ No	When _____	Abnormal?	_____	
Screening Lung CT	☐ Yes	☐ No	When _____	Abnormal?	_____	
Screening Colonoscopy	☐ Yes	☐ No	When _____	Abnormal?	_____	
Screening for Glaucoma	☐ Yes	☐ No	When _____	Abnormal?	_____	

Discuss with Provider

Nutrition Counseling	☐ Yes	☐ No
End-of-Life Planning	☐ Yes	☐ No
Living Will	☐ Yes	☐ No
Durable Power of Attorney for Medical Affairs	☐ Yes	☐ No