Your Annual **Wellness Visit** Questionnaire

Member Name: ________________________________
Date of Birth: ________________________________
PCP's Name: ________________________________

Date of Annual Wellness Visit: ___________________

Bring this completed form to review with your doctor at your **Annual Wellness Visit**. Some items may not apply to you. A physical exam is **NOT** included in this visit. *Do not use this visit for a physical or routine office visit.*

Patient Section : (please fill out before your visit)

Family History

____
____

Physical health: Any change from last year? Y/ N
Past Medical History/ Past Surgical History

____
____
____
____

Current Medicines/Vitamins/Supplements **CPT II 1159F AND 1160F (if opioids or narcotics are listed please assess risk)*

____
____
____
____

Do you need help managing your medicines? Y / N

Allergies ____________________________________
____

Please list any other Doctors caring for you:
(Name/Specialty/Reason)

____
____
____

Please list medical supplies/equipment & vendors

____
____

Do you have an **Advanced Directive**? Y / N
**CPT II – 1158F*

Do you have a Durable Power of Attorney? Y/ N
(Name/Number) ________________________________

How do you rate your **health** in general?
Poor Fair Good Very good Excellent

Do you walk/**exercise** 3 or more times a week? Y / N

Urine: Any leakage? Y / N **CPT II – 1090F*

Do you have to strain to **hear**/understand conversations? Y / N

Balance: **CPT II – 0518F*
Do you feel unsteady walking or standing? Y / N
Have you fallen in the past year? Y / N
If Yes, how many times? ____

Chronic Pain: rate the level of your pain
(No Pain) 0 1 2 3 4 5 (Severe)
(*none *1126F)* *(*chronic or daily pain present CPT II - 1125F)*

Compared to a few years ago, do you have MORE trouble:
Remembering things that happened recently? Y / N
Recalling conversations after a couple of days? Y / N
Trouble paying bills/managing money? Y / N
**CPT II – 3755F*

Social & emotional: Do you have support from friends or family? Y / N

Do you need help with these activities? **CPT II – 1170F*
(Please circle all that apply)
eating, bathing, dressing or **toileting, shopping, and/or cooking**

Habits: (*please check if you ...)*
□ Smoke: (#) ___ /day for (#) ____ years *(*1000F)*
□ Drink Alcohol: (#) ____ per day / week / month
□ Recreational substances: ____ per day / week / month

Does your Home have: *(check all that apply)*
Working detectors: □ Smoke □ Carbon Monoxide
□ Firearms (Guns) □ Throw rugs □ Non-slip bath mat
□ Stairs □ Handrails

Safety: Do you drive? Y / N
Wear seatbelts in the car? Y / N

Nutrition: Did you lose or gain more than 5 lbs. in the last month? Y / N

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)				
Over the **last 2 weeks**, how often have you been bothered by any of the following problems?				
	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
If you answered "Not at all" to both questions above, you may STOP HERE				
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have to let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
(office use only) Totals				
(office use only) Total Score				

If you checked off ANY problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (please circle)

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CPT II: 3725F

Your Personalized Prevention Plan

Member Name: ______________________________
Date of Birth: ______________________________
PCP's Name: ______________________________

Date of Annual Wellness Visit: _______________

This is your personalized Prevention Plan. Some items may not apply to you.

Ht _____ Wt _____ BMI ____
(Healthy BMI: 19-24.9; Obese >30)

Blood Pressure ____ / ____
(Patient age 18-59 goal < 140/90, age 60-85 goal <150/90)

Welcome to Medicare/IPPE only
Eye Exam/Vision
Right (OD) ____ / ____
Left (OS) ____ / ____

EKG Y / N

	RECOMMENDED SCREENING TESTS AND PREVENTION			Referral Given
	Glaucoma Screening	Date:		
	Colon Cancer Screening	Name of Test:	Date:	
	Mammogram	Date Completed:		
	Bone Density	Date Completed:		
	Cholesterol Test	Your Results	Reference Ranges	
		Total Chol: HDL (good): LDL (bad) Trig (fats):	Normal <200, High >240 Better if higher; Best >60 Best <100 (<70 if heart dz) Normal <155, High >200	
	Blood Sugar / Diabetes	Fasting Sugar:	Normal <100; Diabetes >126	
	Vaccines	Pneumonia :		
		Shingles :		
		Tetanus/Tdap /Td (*10years)* :		
		Flu (needed *every year* in the Fall) :		
		COVID-19:		
		(other vaccines) :		
	Advanced Directive	Copy Received/Completed :		Form Given?
		Come back for your Next Visit:		

Counseling recommendations provided for (*check those that apply*)

- ☐ Fall prevention
- ☐ Home Safety
- ☐ Nutrition
- ☐ Physical activity
- ☐ Tobacco-use cessation
- ☐ Alcohol Reduction
- ☐ Weight loss
- ☐ Dental Evaluation
- ☐ Depression follow up
- ☐ Pain/Sleep medication safety