Medicare Annual Wellness Assessment

Patient. Name: ________________________________ Date:________________
DOB: ____________________ Spoken Language:_________________________
Who is completing this form: □ myself □ family member □ friend □ other ______________
Rate your overall health: □ excellent □ very good □ good □ fair □ poor

How many times per week do you do the following? (Select the answer)
1. Engage in physical activity (e.g. walking, cycling, etc.) for at least 20 to 30 minutes? □ 0 □ 1 – 2 □ 3 – 4 □ >5
2. Include strength exercises (weights or resistance bands) in your physical activity routine? □ 0 □ 1 – 2 □ 3 – 4 □ >5
3. Eat 5 or more servings of fruits and vegetables (one serving equals 1/2 cup)? □ 0 □ 1 – 2 □ 3 – 4 □ >5
4. Eat 5 or more servings of grains (one serving equals one slice of bread, 1 cup of cereal, etc.)? □ 0 □ 1 – 2 □ 3 – 4 □ >5
5. Eat 2 or more servings of dairy products (milk, yogurt or cheese)? □ 0 □ 1 – 2 □ 3 – 4 □ >5
6. Eat fast food? □ 0 □ 1 – 2 □ 3 – 4 □ >5
7. Cut the size of your meals or skip meals because you don’t have enough food (not enough money or enough help to shop or cook)? □ 0 □ 1 – 2 □ 3 – 4 □ >5
8. Have more than one drink of alcohol (beer, liquor, wine) per day? □ 0 □ 1 – 2 □ 3 – 4 □ >5
9. Get at least 7 hours of sleep? □ 0 □ 1 – 2 □ 3 – 4 □ >5
10. Use tobacco or nicotine products (cigarettes, e-cigarettes, smokeless tobacco, cigars, or pipes) or are close to others who do? □ 0 □ 1 – 2 □ 3 – 4 □ >5
11. Leave your home to run errands, go to work, go to meetings, classes, church, social functions, etc. (not counting doctor’s visits)? □ 0 □ 1 – 2 □ 3 – 4 □ >5
12. Have physical pain that affects your activities? □ 0 □ 1 – 2 □ 3 – 4 □ >5
13. Do you visit your dentist for regular check-ups at least every six months if you have natural teeth, or once a year if you have full dentures? □ Yes □ No
14. Do you have enough money to pay for the medications, medical supplies, and medical visits that you need? □ Yes □ No
15. About how many times in the last month have you missed taking your medications? ________ times □ I don’t take medicines
16) About how many times in the last month have you taken your medication differently than prescribed by your doctor? (skip if you don’t take medicines) _______ times

17) Do you take any over-the-counter medications (vitamins, supplements, herbal medicines)? □ Yes □ No

18) Do you have sufficient transportation to make all of your medical appointments? □ Yes □ No

19) In the past 12 months, have you had any problem with balance or walking, or have you had any falls? If Yes to falls, how many times? ______ □ Yes □ No

20) In the past 6 months, have you had a problem with leakage of urine? □ Yes □ No

21) In the past month, have you needed help managing your finances? □ Yes □ No

22) Do you think anybody is taking or using your money without your permission? □ Yes □ No

23) In the past 7 days, have you needed help from others:

24) To eat, bathe, get dressed or use the toilet? □ Yes □ No

25) To do laundry, cooking, housekeeping or shopping? □ Yes □ No

26) For transportation? □ Yes □ No

27) To take your medications? □ Yes □ No

28) Do you or your caregiver have sufficient help/support with and resources for caregiving duties? (skip if you do not give or receive care) □ Yes □ No

29) Are you satisfied with your current level of social interaction with family and friends, and participation in activities outside your home? □ Yes □ No

30) Do you have family and friends who care about you and you can count on for help when you need something or have a problem? □ Yes □ No

31) Is anybody mistreating you? □ Yes □ No

32) Do you have an Advance Directive or Living Will? □ Yes □ No

Over the last two weeks, how often have you been bothered by the following problems? □ not at all □ several days □ > half of the days □ nearly every day

33) Little interest or pleasure in doing things? □ not at all □ several days □ > half of the days □ nearly every day

34) Feeling down, depressed or hopeless? □ not at all □ several days □ > half of the days □ nearly every day

35) Having anxiety or stress about your health, finances, family, work or social relationships? □ not at all □ several days □ > half of the days □ nearly every day

For Provider Use Only

Height: _______ Weight: _______ BMI: _______ BP: ____/____ P:_____

PHQ-2 Score: ____ PHQ-9 Score (if indicated): ______

Other mental health screen, if indicated: (name/score) ______
Mini-Cog Score: _______ Other cognitive screen, if indicated: (name/score) ____________

Timed Up and Go: ___________________________________________________

☐ Home safety checklist reviewed
☐ Personal Preventive Plan completed and reviewed with patient

Information/education provided:
☐ Exercise ☐ Healthy Eating ☐ Dietary supplements ☐ Food Banks/Meals on Wheels
☐ Fall prevention ☐ Pain ☐ Depression ☐ Sleep
☐ Cognitive impairment ☐ Medication use ☐ Transportation resources
☐ Caregiver resources ☐ Abuse prevention ☐ Scam prevention
☐ Veteran’s benefits ☐ Health Insurance Counseling Advocacy Program (HICAP)
☐ Speech/hearing center ☐ Braille Institute ☐ Advance Directive/Living Will
☐ Adult Day Care ☐ Alzheimer’s Association ☐ Long Term Support Services (LTSS)
☐ Other __________________________________________

Referrals made/provided:
☐ Dental ☐ Optometry ☐ PT evaluation ☐ Pain management ☐ Dementia evaluation
☐ Psychiatry/Counseling/behavioral health ☐ Dietician/nutrition counseling
☐ Bone Mineral Density ☐ Colonoscopy ☐ Mammogram ☐ Pap smear
☐ Alcohol reduction ☐ Tobacco cessation ☐ Chronic Disease Self-Management Class
☐ Case management ☐ Driving evaluation ☐ Friendly visitor program
☐ Other __________________________________________